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ABSTRACT

This congressional hearing consists of testimony on the nursing shortage facing the country. It examines the causes and impact of the nursing shortage that the nation faces and introduces innovative remedies currently being undertaken by educational institutions and the health care industry, and makes suggestions for further action. Testimony includes statements from members of Congress on the Committee on Education and the Workforce and representing a district in the State of New York, and individuals representing Washington Hospital Center, Washington, DC; Inova Fairfax Hospital, Virginia; American Nurses Association, Washington, DC; College of the Canyons, California; Nurse Alliance, Service Employees International Union, Washington, DC; School of Nursing, Georgia Southern University, Georgia; College of Nursing and Health Sciences, University of Phoenix, Arizona; and American Hospital Association, Washington, DC. Appendixes include written statements and letters of committee members, representatives, and individuals representing the above named associations and institutions and the American Association of Community Colleges, Washington, DC; American Association of Nurse Anesthetists; Partners for a Healthy Community; Premier, Inc., Washington, DC; Department of Health and Human Services; Department of Education; American Federation of State, County, and Municipal Employees; and Employment Policy Foundation. (YLB)

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THE NURSING SHORTAGE: CAUSES, IMPACT, AND INNOVATIVE REMEDIES

HEARING

BEFORE THE

COMMITTEE ON EDUCATION AND THE WORKFORCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, SEPTEMBER 25, 2001

Serial No. 107-31

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TABLE OF CONTENTS

OPENING STATEMENT OF CHAIRMAN JOHN BOEHNER, COMMITTEE ON EDUCATION AND THE WORKFORCE 2

OPENING STATEMENTOF RANKING MEMBER GEORGE MILLER, COMMITTEE ON EDUCATION AND THE WORKFORCE 4

STATEMENT OF CONGRESSWOMAN SUE KELLY, 19th DISTRICT OF NEW YORK, U. S. HOUSE OF REPRESENTATIVES 5

STATEMENT OF CONGRESSWOMAN CAROLYN McCARTHY, COMMITTEE ON EDUCATION AND THE WORKFORCE 7

STATEMENT OF MELISSA VELAZQUEZ, RN, BURN INTENSIVE CARE UNIT, WASHINGTON HOSPITAL CENTER, WASHINGTON, D.C. 9

STATEMENT OF LISA TOMPKINS, RN, BSN, TRAUMA/NERUO INTENSIVE CARE UNIT, INOVA FAIRFAX HOSPITAL, FALLS CHURCH, VA 11

STATEMENT OF MARY FOLEY, RN, MS, PRESIDENT, AMERICAN NURSES ASSOCIATION, WASHINGTON, D.C. 34

STATEMENT OF SUE ALBERT, RN, MN, MHA, ASSISTANT DEAN OF ALLIED HEALTH, COLLEGE OF THE CANYONS, SANTA CLARITA, CA 37

STATEMENT OF CAROLYN McCULLOUGH, MA, RN, NATIONAL COORDINATOR, NURSE ALLIANCE, SERVICE EMPLOYEES INTERNATIONAL UNION, WASHINGTON, D.C 39

STATEMENT OF DR. JEAN BARTELS, CHAIR, SCHOOL OF NURSING, GEORGIA SOUTHERN UNIVERSITY, STATESBORO, GA 42

STATEMENT OF CATHERINE GARNER, DrPH, RN, FAAN, DEAN, COLLEGE OF NURSING AND HEALTH SCIENCES, UNIVERSITY OF PHOENIX, PHOENIX, AZ 45

STATEMENT OF GEORGE F. LYNN, PRESIDENT AND CEO, ATLANTICARE HEALTH SYSTEM, TESTIFYING ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, D.C. 47

APPENDIX A - WRITTEN STATEMENT OF CHAIRMAN JOHN BOEHNER, COMMTITEE ON EDUCATION AND THE WORKFORCE 59

APPENDIX B - WRITTEN STATEMENT OF CONGRESSWOMAN SUE KELLY, 19TH DISTRICT OF NEW YORK, U.S. HOUSE OF REPRESENTATIVES 63

APPENDIX C - WRITTEN STATEMENT OF CONGRESSWOMAN CAROLYN McCARTHY, COMMITTEE ON EDUCATION AND THE WORKFORCE 67

APPENDIX D - WRITTEN STATEMENT OF MELISSA VELAZQUEZ, RN, BURN INTENSIVE CARE UNIT, WASHINGTON HOSPITAL CENTER, WASHINGTON, D.C. 73

APPENDIX E - WRITTEN TESTIMONY OF LISA TOMPKINS, RN, BSN, TRAUMA/NEURO INTENSIVE CARE UNIT, INOVA FAIRFAX HOSPITAL, FALLS CHURCH, VA 77

APPENDIX F - WRITTEN STATEMENT OF MARY FOLEY, RN, MS, PRESIDENT, AMERICAN NURSES ASSOCIATION, WASHINGTON, D.C. 83

APPENDIX G - WRITTEN STATEMENT OF SUE ALBERT, RN, MN, MHA, ASSISTANT DEAN OF ALLIED HEALTH, COLLEGE OF THE CANYONS, SANTA CLARITA, CA 99

APPENDIX H - WRITTEN STATEMENT OF CAROLYN McCULLOUGH, MA, RN, NATIONAL COORDINATOR, NURSE ALLIANCE, SERVICE EMPLOYEES INTERNATIONAL UNION, WASHINGTON, D.C. 111

APPENDIX I - WRITTEN STATEMENT OF DR. JEAN BARTELS, CHAIR, SCHOOL OF NURSING, GEORGIA SOUTHERN UNIVERSITY, STATESBORO, GA 123

APPENDIX J - WRITTEN STATEMENT OF CATHERINE GARNER, DrPH, RN, FAAN, DEAN, COLLEGE OF NURSING AND HEALTH SCIENCES, UNIVERSITY OF PHOENIX, PHOENIX, AZ 141

APPENDIX K - WRITTEN STATEMENT OF GEORGE F. LYNN, PRESIDENT AND CEO, ATLANTICARE, TESTIFYING ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, D.C. 147

APPENDIX L – SUBMITTED FOR THE REOCRD, STATEMENT OF CONGRESSWOMAN LOIS CAPPS, 22ND DISTRICT OF CALIFORNIA, U.S. HOUSE OF REPRESENTATIVES, SEPTEMBER 25, 2001 159

APPENDIX M – SUBMITTED FOR THE RECORD, STATEMENT OF CONGRESSMAN RUSH HOLT, 12TH DISTRICT OF NEW JERSEY, U.S. HOUSE OF REPRESENTATIVES, SEPTEMBER 25, 2001 163

APPENDIX N – SUBMITTED FOR THE RECORD, LETTER FROM GEORGE R. BOGGS, PRESIDENT AND CEO, AMERICAN ASSOCIATION OF COMMUNITY COLLEGES, WASHINGTON, D.C., TO BONNIE LEBOLD, EXECUTIVE DIRECTOR, NATIONAL ADVISORY COMMITTEE ON INSTITUTIONAL QUALITY AND INTEGRITY, U.S. DEPARTMENT OF EDUCATION, WASHINGTON, D.C., AUGUST 27, 2001 167

APPENDIX O – SUBMITTED FOR THE RECORD, STATEMENT OF KAREN DRENKARD, RN, MSN, CNAA, CHIEF NURSE EXECUTIVE, INOVA HEALTH SYSTEM, FALLS CHURCH, VA, SEPTEMBER 11, 2001 173

APPENDIX P – SUBMITTED FOR THE RECORD, STATEMENT OF DEBORAH A. CHAMBERS, CRNA MHSA, PRESIDENT, AMERICAN ASSOCIATION OF NURSE ANESTHETISTS – FEDERAL GOVERNMENT AFFAIRS OFFICE, WASHINGTON, D.C., SEPTEMBER 24, 2001 183

APPENDIX Q – SUBMITTED FOR THE RECORD, STATEMENT OF DR. PAUL KINSER, PROVOST OF THE WEST CAMPUS, VALENCIA COMMUNITY COLLEGE AND NANCY DINON, VICE PRESIDENT, HUMAN RESOURCES, ORLANDO REGIONAL HEALTHCARE, ON BEHALF OF PARTNERS FOR A HEALTHY COMMUNITY, SEPTEMBER 25, 2001 189

APPENDIX R – SUBMITTED FOR THE RECORD, STATEMENT OF PREMIER, INC., WASHINGTON, D.C., SEPTEMBER 25, 2001, AND LETTERS FROM HERB KUHN, CORPORATE VICE PRESIDENT, ADVOCACY TO THE HONORABLE TOMMY TOMPSON, SECRETARY OF HEALTH AND HUMAN SERVICES, SEPTEMBER 20, 2001 AND THE HONORABLE ROD PAIGE, SECRETARY OF EDUCATION, JANUARY 22, 2001 193

APPENDIX S – SUBMITTED FOR THE RECORD, STATEMENT OF THE AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, SEPTEMBER 25, 2001 205

APPENDIX T - SUBMITTED FOR THE RECORD, STATEMENT OF EMPLOYMENT POLICY FOUNDATION, WASHINGTON, D.C., SEPTEMBER 25, 2001 211

Table of Indexes 220

THE NURSING SHORTAGE:
CAUSES, IMPACT, AND INNOVATIVE REMEDIES

Tuesday, September 25, 2001

Committee on Education and the Workforce

U. S. House of Representatives

Washington, D.C.

The Committee met, pursuant to call, at 10:00 a.m., in Room 2175, Rayburn House Office Building, Hon. John A. Boehner, Chairman of the Committee, presiding.

Present: Representatives Boehner, Ballenger, McKeon, Castle, Greenwood, Norwood, Ehlers, Fletcher, Isakson, Goodlatte, Biggert, Tiberi, Osborne, Miller, Kildee, Mink, Andrews, Roemer, Scott, Woolsey, Hinojosa, McCarthy, Tierney, Kucinich, Wu, Holt, Solis, Davis, and McCollum.

Staff Present: Stephanie Milburn, Professional Staff Member; Victoria Lipnic, Professional Staff Member; Dave Thomas, Legislative Assistant; John Cline, Professional Staff Member; Molly Salmi, Professional Staff Member; Jo-Marie St. Martin, General Counsel; Heather Valentine, Press Secretary; Patrick Lyden, Professional Staff Member; Deborah L. Samantar, Committee Clerk/Intern Coordinator; Peter Rutledge, Senior Legislative Associate/Labor; Michele Varnhagen, Labor Counsel/Coordinator; Maria Cuprill, Legislative Associate/Labor; Maggie McDow, Legislative Associate/Education; Brendan O'Neil, Legislative Associate/Education; Brian Compagnone, Staff Assistant/Labor.

Chairman Boehner. A quorum being present, the Committee on Education and the Workforce will come to order. We are meeting today to hear testimony on problems associated with the Nation's nursing shortage. And under Committee Rule 12(b), opening statements are limited to the Chairman and Ranking Minority Member of the Committee. Therefore, if other Members have statements, they will be included in the hearing record.

And with that, I ask unanimous consent for the hearing record to remain open for 14 days to allow Member statements and/or extraneous material referenced during this morning's hearing to be submitted in the official hearing record. Without objection, so ordered.

OPENING STATEMENT OF CHAIRMAN JOHN BOEHNER, COMMITTEE ON EDUCATION AND THE WORKFORCE

I thank you for joining us this morning for this hearing. Today this Committee is meeting to hear testimony on the nursing shortage facing our country. As most of you know, this hearing was originally scheduled to take place 2 weeks ago today, September 11th.

Among the many things we have awoken to since that fateful day is the importance of the women and men who make up our Nation's medical and emergency professions. If the nursing shortage facing our country was in serious condition 2 weeks ago, it is in critical condition today. Two weeks ago we watched dedicated nurses and other medical personnel selflessly respond to tragic events in New York City and right across the river at the Pentagon.

Today we have with us on our panel and in our audience nurses who were there to care for others in that time of need. We want to thank you for your willingness to join us today and for your dedicated response in that emergency. And more than that, we are grateful to you and to all of your colleagues for your chosen profession.

The choice of nursing is at the heart of what we examine here today. If ever an issue demonstrates the lifeblood connection between education and the workplace, this is certainly it. The nurses make up the backbone of our health care system. They provide much of the direct care all of us receive. Nursing requires exacting and continuing education and skill. And while we all know that nursing can be one of the most rewarding professions, at the same time it is the one of the most mentally and physically demanding careers that one can choose.

And so today we will examine the causes and impact of the nursing shortage that we face in our country. We expect to hear about innovative remedies currently being undertaken by educational institutions and the health care industry as well as suggestions for further action.

I want to thank our witnesses for coming today and giving us the benefit of their perspectives and expertise on this issue. I especially want to acknowledge the appearance of our colleagues, Congresswoman Kelly and Congresswoman McCarthy, who will testify first on our panel today, and, I might add, whose suggestion led to this hearing that we have in front of us today.

Let me provide some additional context for our hearing today. Like many of you, I regularly hear from hospitals in my district about the difficulty that they are having in recruiting and retaining nurses. And while the individual stories are different, the themes are the same.

Demand for nurses continues to increase as the population ages and acuity levels of patients increase. At the same time, nurses are leaving the hospital setting for other opportunities. And while hospitals are making the changes to the nursing workplace to make employment more attractive, recruitment efforts have not succeeded in filling all of the empty positions. As a result, staffing challenges are exacerbated. In addition, the nursing workforce is aging. Fewer new nurses are entering the profession to replace those who are retiring or leaving. The average age of the nurse is now just over 43 years.

Unfortunately, fewer younger people are choosing to pursue a career in nursing, and enrollment in all of the nursing education programs has in fact declined. Certain populations remain underrepresented in the nursing field; included in them are men and minorities. Hospitals are experiencing tremendous vacancy rates for nursing positions, and overall, the pipeline of new graduates from nursing programs is insufficient to keep pace with the demand.

And while providers in many areas of the country say they currently face a crisis, the shortage is only expected to worsen. By 2020, as baby boomers reach their late sixties and seventies and need more health care, the nursing workforce is projected to fall to nearly 20 percent below projected needs.

Now, we have new issues that may impact the profession. For instance, we do not yet know how many nurses in the military reserves may be called into active duty. In addition, recent events have forced us to evaluate our emergency preparedness around the country.

Through this hearing I hope that we will bring needed attention to the growing shortage and provide a venue for exchange of ideas on possible solutions. Strategies to address the nursing shortage could impact education, training, and workforce programs. I anticipate that we will learn that there are no easy solutions to address this situation.

However, our discussion today likely will reinforce the fact that all parties, whether they are educators, nurses, employers or the government, need to work together to reach out to young people and underrepresented groups to encourage them to become nurses. And we need to do everything that we can to keep current nurses working in the profession, and I look forward to hearing the suggestion of our witnesses.

WRITTEN STATEMENT OF CHAIRMAN JOHN BOEHNER, COMMTITEE ON EDUCATION AND THE WORKFORCE – SEE APPENDIX A

Chairman Boehner. It is now my pleasure to yield to my friend and Ranking Member of the Committee, Mr. Miller.

OPENING STATEMENTOF RANKING MEMBER GEORGE MILLER, COMMITTEE ON EDUCATION AND THE WORKFORCE

Thank you, Mr. Chairman, very much for holding this hearing and for your opening remarks. I too want to join you in welcoming those in our audience today who participated in helping those who were so devastated and harmed by the events of September 11th.

But I think, as we will hear from these witnesses today and as we have already heard from so many nurses in our own community, it may be that the events of September 11th simply put a very, very bright spotlight on the situation that exists in all of our communities on a daily basis. The difficulty of responding to community emergencies, the difficulty of trying to retain a coherent workforce in our various medical facilities exists on a day-to-day, ongoing basis all of the time.

We are now into that situation where fewer and fewer people are coming into the profession because they have alternatives which is making the profession more and more difficult, so more and more people are leaving. And I think that at the end of this hearing, if it goes as I expect, and if it is consistent with what I have heard from so many in the profession in the San Francisco Bay area, our response is going to have to be comprehensive. We are going to have to try to improve the situation for those who are already in the profession so they will want to stay, so they will want to continue that career. And we are clearly going to have to make it more attractive at the same time for those about to enter. But nobody should be mistaken about the urgency of this problem. Everywhere in the entire health care chain you can engage anyone and they will tell you about the problems because of the lack of nurses.

I would like, if I might, Mr. Chairman, ask unanimous consent to insert the statement of Congresswoman Lois Capps, on this issue. I would just like to_the part of it where she states: In our State of California, less than 10 percent of the registered nurse workforce is under the age of 30, and nearly a third of it are over the age of 50, and we rank 50th among the States in RNs per hundred thousand people.

It is an acute problem. It is a serious problem. And we are going to have to certainly lend a Federal effort to solving this problem, and I look forward to hearing from our panels today.

Thank you again for holding the hearing.

Chairman Boehner. I would now like to introduce our first panel of witnesses. Our first witness is the gentlelady from New York, Representative Sue Kelly. Testifying second will be our other colleague, the gentlelady from New York and a Member of this Committee, Carolyn McCarthy. Our third witness will be Ms. Melissa Velazquez, RN from the Burn Intensive Care Unit of the Washington Hospital Center. And our final witness on the panel will be Ms. Lisa Tompkins, RN, BSN. Ms. Tompkins is a registered nurse from the Trauma/Neuro Intensive Care Unit, Inova Fairfax Hospital in Northern Virginia. I would like to remind my colleagues that we do have a 5-minute rule on questioning.

I will explain to our witnesses the lights in front. You will have a green light for 4 minutes, a yellow light for a minute, and when it gets to red we hope that you would be concluding your remarks. Because we have two panels of witnesses today, and a vote is expected on the floor sometime during this morning, we want to try to hold to our time limits.

I understand the gentlelady from New York, Ms. Kelly, who also sits on the Aviation Subcommittee, Committee on Transportation and Infrastructure may have to leave. Therefore, Ms. Kelly, you may begin.

STATEMENT OF CONGRESSWOMAN SUE KELLY, 19th DISTRICT OF NEW YORK, U. S. HOUSE OF REPRESENTATIVES

Thank you, Mr. Chairman and Members of the Committee, for inviting me to testify about this nursing shortage. It is a growing problem with the potential to impair health care delivery in our Nation. I am pleased that the Committee has recognized the severity of this issue and convened this hearing.

No doubt you hear all the heart-wrenching accounts from hospitals, skilled nurses, and long-term care facilities in your district about the difficulty they face in filling their nursing staffing slots. The crisis is real. I have seen it in hospitals in my district and appreciate the opportunity to appear here today to discuss both short- and long-term solutions to this problem.

Now more than ever, attention is focused on the ability of health care personnel to respond to critical patient needs. Our Nation's nurses are among the many heroes who responded to the recent attacks on the Pentagon and World Trade Center. The New York Nursing Association has told me of the overwhelming support from nurses in New York and around the country who volunteered to care for victims and rescuers in New York City at Ground Zero. I have met and spoken with nurses who returned there to work on their days off after hearing of the attacks on the news.

This kind of service defines the nursing profession. Nursing is a tough job, both mentally and physically. Nurses put their own health and safety at risk daily in the course of their jobs. Nursing can be a very rewarding profession, but, unfortunately, I have heard from many nurses that they would not recommend the profession to friends or family unless major changes take place in the industry.

The shortage of nurses in our Nation's hospitals and the pending retirement of many nurses should be worrisome to all of us. Hospitals can't run without nurses. RNs comprise the largest group of health care providers. Without adequate nursing staff, hospitals are forced to close units, turn away patients and redirect their emergency cases.

This results in long waits and a reduced quality of care. In critical situations, timing is everything. And when patients have to travel further or wait longer for care, they are less likely to have a positive recovery time.

The average age of a nurse in New York State is 48 years old. The average retirement age in New York is 52. The number of nurses approaching retirement, coupled with the aging baby boomer population who will require care, only increases the need for nurses. Looking down the road, the population of those aged 65 and older is expected to double in the next 30 years.

The cumulative effect of all of that is nurses are leaving the profession rapidly at a time when we need them most. It is imperative that we focus on these problems that will bring more nurses into our health care facilities and faculty into our nursing schools.

I am introducing new legislation aimed at combating the nursing shortage. I am collaborating with Senators Tim Hutchinson and Barbara Mikulsky who have already introduced The Nursing Employment and Education Development Act or the Need Act in the Senate. In short, the Need Act provides a framework for increasing the awareness of opportunities in the nursing profession, growing the enrollment in nursing schools, and providing staff coverage for areas experiencing more acute shortages.

The Need Act expands nursing loan repayment programs and establishes a Nurse Service Authority so nurses can receive scholarships in exchange for postgraduate service in geographic areas experiencing shortages. It expands the list of eligible entities at which they can fulfill this service requirement to include nursing homes, home health agencies, public health departments and nurse-managed health centers.

The bill will focus on attracting students to nursing by educating them about the benefits of nursing, offer grants for multimedia outreach and public awareness campaigns, and help ensure adequate registration at nursing schools in order to retain and strengthen our existing nurse workforce. The Need Act contains career ladder provisions to encourage nurses and nurses' aids to pursue advanced degrees so they can increase the level of care they can provide. Additionally the bill provides grants to encourage mentoring internship and residency programs as well as programs to bring former nurses back into the field. There are quite a few nurses who have left the field. We need to bring them back.

The bill also contains provisions for fast-track faculty development at nursing schools so there are well-qualified nurse educators to replace those retiring. This provision encourages Masters and Doctoral students to expedite their studies through loans and scholarships.

The answer to the nursing shortage is really fairly simple: Nurses need to have better hours, they need less paperwork, and they need better pay. We need to do everything that we can do to encourage them to stay in the field and bring them back into the field. We need to help them achieve staying in the nursing profession.

Again I commend the Committee for holding this hearing today in order to explore solutions to the nursing shortage. I look forward to the testimony of the second panel and to working with all of the Members of this Committee to get more nurses into our hospitals and to secure the future of nurses. I am happy to answer any questions.

WRITTEN STATEMENT OF CONGRESSWOMAN SUE KELLY, 19TH DISTRICT OF NEW YORK, U.S. HOUSE OF REPRESENTATIVES – SEE APPENDIX B

Chairman Boehner. Sue, thank you.

Mrs. McCarthy, you may begin.

STATEMENT OF CONGRESSWOMAN CAROLYN McCARTHY, COMMITTEE ON EDUCATION AND THE WORKFORCE

Thank you, Chairman Boehner, and Representative Miller for the opportunity to testify before my colleagues on the Education and Workforce Committee. I have always been proud to serve on the Subcommittee on Education Reform, but I am especially proud today because we are focusing on an issue that is very important to me personally and professionally.

Mr. Chairman, before coming to Congress, I spent over 30 years as a nurse on Long Island. And even now, I know that there isn't a better career in world or better training than nursing to be a Member of Congress. The only difference today is I have a lot more patients here in Congress and certainly at home.

That is why I am particularly saddened when we talk about the nursing shortage. And let's be honest, right now we are in the middle of a national nursing crisis. I have been talking about this for almost 5 years since I came to Congress. Of the estimated 2.5 million licensed nurses in our country, 400,000 have left the profession for other pursuits. In the year 2000 alone, Long Island has had an 8 percent RN vacancy rate, and a dangerously low 16 percent LPN vacancy rate. It is startling to learn that hospitals need about 126,000 nurses to fill all of the nursing positions available today.

Mr. Chairman, the crisis will only get worse in the future. The demand for more nurses will dramatically increase as the baby boomer generation ages. And like the general population, the nurse workforce is aging while enrollment in nursing education programs has dramatically declined over the past 5 years. Between 1995 and 1998, there was a 21 percent decrease in the number of people enrolling in nursing schools. In addition, enrollment in the Bachelor of Science in Nursing programs was down 5 percent in 1999. This is especially troubling when taking into account that nurses have been leaving the field at record rates.

The booming economy of the 1990s increased job opportunities for practicing nurses, but reductions in Medicare reimbursements resulted in a shift from inpatient to outpatient care. This left the most ill patients in the hospitals creating a more stressful environment for nurses who stayed in the field of high-risk patient care areas. Intensive care units and emergency rooms require highly skilled nurses with significant experience and have been affected most by the shortage.

As a nurse, I can tell you that getting the right care in the first 24 hours of being in the intensive care unit can make all of the difference in whether or not you recover from life-threatening problems. Further, if you do survive, the kind of care you receive within the first 24 to 48 hours dictates how long recovery will take.

When I speak to the health care professionals or visit the hospitals in my District, I hear the same thing from the nurses I meet: "I love my job, but the sacrifices I make are too great." Let's be honest nobody ever went into nursing to make money, but like our teachers, nurses deserve better, and like teaching, nursing has traditionally been a profession made up mostly of women. In 2000, men held less than 6 percent of nursing positions.

Over the past 20 years, professional opportunities for women have grown greatly. Many women who years ago would have gone into nursing are now breaking new ground in technology, business, and politics. Unfortunately, what hasn't changed over the last 20 years is how much we pay our nurses.

Mr. Chairman, we have outlined the problems. Now what about the solutions?

There are many things we can do to combat the worker shortage. First, we need to recruit qualified, educated students. Our students have so many choices for careers today; we need to make nursing a competitive option. One way to do this is to increase funding for the nurse loan repayment program and designate the income as nontaxable. We need to further increase reimbursement rates to hospitals so they can increase nursing salaries. If nurses were compensated as other professionals are, more students would want to enter the profession. Finally, we have to create incentives for nurses to stay in nursing upon training completion. We should provide grants to encourage nurses to upgrade their skills in clinical specialty areas that have shortages. We must work with our hospitals to improve working conditions for our nurses.

Mr. Chairman, solving the nursing shortage was extremely important before September 11th. Now more than ever it is vital to our Nation's health care, which is why it is my privilege to share this panel with Melissa from Washington, D.C., and Lisa from Falls Church, Virginia, two nurses who responded to our national tragedy and worked diligently to save the lives of our wounded. I commend them for their hard work and the hard work of all of our emergency personnel, and I look forward to their testimony.

Just on a side note: I talked my sister into going into nursing about 7 years ago and, unfortunately, 2 years ago, which is the average, she left nursing. She loved it. She loved the work that she was doing. But I will tell you, on her day off, she didn't want to answer the phone because she knew it was the hospital calling her to come in.

These are the crises that we are facing on a daily basis. We have to make sure our hospitals have the money to support the nursing staff which provides the whole infrastructure of our hospital care system that obviously goes right to the heart of taking care of patients. We have to do something. This Committee has the opportunity, in my opinion, to make things easier for people to go into the nursing field, continue in their education, and make a difference for everybody that we love, because someday, eventually, every single one of us will be spending time in the hospital.

I look forward to the questions that anyone on the Committee has to ask me. Thank you.

WRITTEN STATEMENT OF CONGRESSWOMAN CAROLYN McCARTHY, COMMITTEE ON EDUCATION AND THE WORKFORCE – SEE APPENDIX C

Chairman Boehner. Mrs. McCarthy, thank you. Ms. Velazquez, you may begin.

STATEMENT OF MELISSA VELAZQUEZ, RN, BURN INTENSIVE CARE UNIT, WASHINGTON HOSPITAL CENTER, WASHINGTON, D.C.

Good morning, Mr. Chairman, and Members of the Committee. My name is Melissa Velazquez. I am a registered nurse at the Burn Intensive Care Unit at the Washington Hospital Center. I thank you for offering this tremendous opportunity to speak to you today.

The spirit that we have seen across the Nation has been nothing less than astounding; the willingness of Americans to take care of their families, their friends, their neighbors, and their communities and ultimately their Nation is overwhelming. It is something that you see and feel everywhere that you go.

If there is one thought that I absolutely want you to take home today, it is that that spirit has been alive and well and thriving in the profession of nursing since its inception, not only in the Burn Intensive Care Unit where we have been given the bittersweet privilege to care for the men and women injured at the Pentagon, but in hundreds of clinical settings all over this country, from the home to the hospital. Nurses give 110 percent of themselves every day they walk through the doors of their facilities.

As the events that day evolved, my priorities changed. I collected my daughter from school, got home safe and made the phone calls necessary to make sure my family was okay. I called my head nurse and she asked if I would come in that night. And, of course, the answer was yes.

In all honesty, I was expecting absolute mayhem. The only other previous experience I had remotely similar was Memorial Day, 2 years ago. Five D.C. Firefighters were injured in a house fire, three of which lost their lives. The flurry of activity that night was unlike any other.

But much to the credit of all that were involved that day of the attack, when I arrived that evening, seven of the eight burn victims from the Pentagon were settled in. And to lend some perspective to that, for just one large burn victim, it takes one doctor, one respiratory therapist, and two to three nurses, not to mention the ancillary support from the other departments such as the laboratory, pharmacy and radiology, a minimum of 2 to 4 hours to settle a patient in, and that is if nothing goes wrong.

The members of the burn team that were there that day did it seven times over, and in a phenomenal amount of time. So how is that possible if the Washington Hospital Center is experiencing the same nursing shortage the rest of the country is? And where did those extra nurses come from?

Over the last year, the burn ICU lost more than half of their staff to different educational and employment opportunities. They simply weren't satisfied with the necessary changes in the work environment that were being made. So why do I mention this? Because those same nurses that left were the same nurses that you saw that day of the attack and in the weeks following.

Why? Because we are nurses. That is what we do. And in a time of need, we put away any differences that we may have and get to the task at hand.

This example speaks volumes to the spirit of the nursing profession. The eighth burn victim hadn't arrived yet. This was to be my patient, Lieutenant Kevin Schaeffer of the U.S. Navy. And before I go on, be assured that I spoke with Lieutenant Schaeffer, and also his wife Blanca and his mother, and gained their permission to talk about him today, although I will not discuss any of his injuries.

There are a few things that stand out in my mind: When his wife arrived that first night and saw him, and the first thing out of her mouth was how much she loved him, and a tremendous amount of emotion came over her. She turned around and buried her hands in her face and cried, but only for a moment because she knew that her husband needed her.

The very next day I had again the privilege to take care of him. And burn victims suffer from a tremendous amount of swelling after their injury, so much so that his eyes were shut on that second night. As I was applying some ointment, his eyes just opened. And I ran to the waiting room and I got Blanca, and I said, "Blanca you've got to come here. I have a surprise for you." And she walked in. And I said, "Kevin, show her what you got." And he opened his eyes. And that is just one of the more tremendous moments I have ever experienced in my career.

This past weekend, Kevin sat up in a chair. He walked to the tank where we take care of cleaning their wounds before they have a new dressing. As a nurse, I have the honor of sharing those moments with Lieutenant Schaeffer and his family. These are the singular moments that make nurses' hearts sing. And as long as those moments outweigh the clinical working environment, I will keep coming back.

There is one final thought I would like to add. And if you were to ask me if there are enough nurses to staff health facilities in the country, the answer would be a resounding no. But, in the case of an emergency, a crisis, the profession of nursing will rise to the occasion, bar none, without fail, just as we have seen in the weeks following the tragedy. And I for one wouldn't change that for the world. Thank you.

WRITTEN STATEMENT OF MELISSA VELAZQUEZ, RN, BURN INTENSIVE CARE UNIT, WASHINGTON HOSPITAL CENTER, WASHINGTON, D.C. – SEE APPENDIX D

Chairman Boehner. Ms. Velazquez, thank you for your testimony.

Ms. Tompkins?

STATEMENT OF LISA TOMPKINS, RN, BSN, TRAUMA/NERUO INTENSIVE CARE UNIT, INOVA FAIRFAX HOSPITAL, FALLS CHURCH, VA

Thank you. Good morning, Mr. Chairman, and Members of the Committee. My name is Lisa Tompkins, a registered nurse who works in the Trauma/Neuro Intensive Care Unit at Inova Fairfax Hospital. It is an honor to be here today to share with you some of the key issues about the nursing shortage that currently faces our Nation.

On September 11th, I stood side by side with my nursing and health care colleagues across the country in a high state of readiness in the face of the one of the worst disasters that this country has seen. Inova Hospital like the rest of the hospitals across this region, including New York and Pennsylvania, went into disaster preparations in the hospitals of being ready to accept and treat patients who needed our care.

My fellow nurses and other health care providers poured into our facilities, many on their days off, to assist. Inova Alexandria Hospital saw 23 victims from the Pentagon site. Inova Fairfax, Fair Oaks, and Mt. Vernon Hospital readied themselves by preparing inpatient bedding, surgery suites, and emergency services to be ready for whatever situation presented.

Like every nurse in the northern Virginia and D.C. Region, our only wish is that we could have done more. We were connected in spirit to our fellow nurses in New York as they stood ready at the doors of their hospitals and in the streets to treat those injured in the attack.

The event underscores the need to ensure the continued and adequate supply of a competent and well-trained nursing workforce in the years to come.

Health care industries across the Nation are experiencing a crisis in nurse staffing, and we are standing on the precipice of an uncertain future about our nursing workforce. The causations of the nursing shortage are increasingly known, and include an aging nursing workforce, a decrease in nursing school enrollment, a poor image of nurses as a career, and job integrity.

The work is rewarding, demanding and at times exhausting. It is a distinct honor to share information about my experience as a nurse and some innovative solutions that I see on the unit where I work.

My clinical background is 5-1/2 years in critical care. In May I will be completing my master's degree in nursing, which has been partially funded by my employer. My clinical competencies include advanced cardiac life support certification, certification in trauma nursing, expertise in the care of patients with ventriculostomies, continuous cardiac output monitoring, continuous bedside dialysis, and trauma resuscitation response to the emergency department.

I care for one to two patients each shift I work, and coordinate the multiple disciplines of care required for a critically injured trauma patient. These patients require a high level of clinical excellence, psychosocial skills, as well as physical labor. I stay in nursing because every day is different and presents new challenges.

I also have the honor of being able to truly affect lives every day in my work. I choose to remain in my unit for numerous reasons. We do our own scheduling, which allows for a large amount of flexibility. We have self-governance, letting staff participate in all levels of decision-making. We have a clinical ladder program that offers promotions and pay increases for levels of clinical excellence at the bedside.

We are reimbursed for education and conferences. There is a great environment of learning, with clinical autonomy and a climate of trust with our physicians. The unit has a strong culture of teamwork and respect, which keeps me going on the hard days, which there are plenty of. Hospital nursing is very hard work that does not get put on hold for nights, weekends, and holidays.

I do work in a great unit with a low vacancy rate, yet we are not exempt from the troubles that are seen by nurses throughout the Nation. Sick calls, short staffing, difficult patient assignments, use of agency nurses, and a desire for increased financial compensation are daily issues.

I believe what nurses need is a combination of attention to the hard stuff including salary, benefits and scheduling, as well as the soft stuff of culture, leadership, education and development.

Although time does not permit, my colleagues and I do have some ideas regarding solutions for a National agenda, which are listed in the written testimony. I will be happy to answer any questions regarding these issues. I love what I do. And my hope for the next generation of nurses is that we address these issues today so that we can continue to provide outstanding care tomorrow.

Thank you, Mr. Chairman, and all members of the committee for the honor of sharing my thoughts with you today.

WRITTEN TESTIMONY OF LISA TOMPKINS, RN, BSN, TRAUMA/NEURO INTENSIVE CARE UNIT, INOVA FAIRFAX HOSPITAL, FALLS CHURCH, VA SEE APPENDIX E

Chairman Boehner. Ms. Tompkins, thank you for your testimony.

We thank all of the witnesses on our first panel for their testimony. We have a vote on the House floor, and we will break now and resume the hearing in about 20 minutes.

The Committee will stand in recess.

[11:15 a.m.]

Chairman Boehner. The Committee will resume its hearing. Under the Committee rules, you each have up to 5 minutes for questions.

I think I would like to ask Ms. Velazquez and Ms. Tompkins this question. What would you share with a young person about your job that you believe would encourage he or she to pursue a career in nursing?

Ms. Tompkins. I would probably start by telling them a story such as Ms. Velazquez just alluded to. That is why we do this, and I think one of our problems with new nurses coming in is that a lot of the nurses currently working are so frustrated that they do not always give a very positive picture of what nursing really is.

Ms. Velazquez. I would encourage youth by saying that nursing is a calling. You touch people's lives. And as in this story that I shared, those are moments that are going to be with me for the rest of my life. Making that connection with people is why I became a nurse. It is certainly not for the money. It certainly is not for the hours. And for those young people that are interested in making that kind of difference, I would encourage them to pursue nursing.

Chairman Boehner. Can you share with us any innovative practices that you see in your hospital and your workplace that make it a positive work environment for you?

Ms. Velazquez. There have been many changes over the last year. I am also an officer of the union at the Washington Hospital Center for the District of Columbia Nurses Association. Last fall, we entered into contract negotiations and we were able to make some changes. But as far as our workplace goes, one of the tremendous advances that we have made was entering into a 36-hour option, which gives us a tremendous amount of flexibility. As far as the workplace goes, that is as much as I am willing to comment on.

Chairman Boehner. Can you outline what the 36-hour option is?

Ms. Velazquez. The 36-hour option is comprised of three 12-hour shifts a week. For example, the way it works for me in my life, I have a 7-year-old and I am a single mom. Lauren's father takes her every weekend, so that affords me every opportunity to work Friday, Saturday, Sunday, so I can be a full-time nurse on the weekend and be a full-time mom to my daughter during the week. That is a tremendous amount of flexibility and that keeps me where I am right now.

Chairman Boehner. Ms. Tompkins?

Ms. Tompkins. I am very fortunate to work in a unit where for the most part everyone is extremely happy with the way things run. We do have many programs in place, which I described in my testimony, such as our self-governance. We have multiple committees. We do peer review evaluations. Self-scheduling is a huge, huge asset. You know, one of the biggest complaints about nursing is the schedule. I don't have that complaint. Yes, you still have to put in your night and your weekend time, but we do three 12-hour shifts a week and you really cannot beat the schedule.

Chairman Boehner. What is self-scheduling?

Ms. Tompkins. We do it ourselves. Basically, on a draft, you pick the days you would like to work. The second draft comes out and we make sure we have enough nurses to do each shift. And in the end, we do sometimes have to make sacrifices to make sure every shift has enough nurses, but it is a wonderful thing to have in place.

Chairman Boehner. Thank you.

Mr. Miller?

Mr. Miller. Thank you very much.

One of the issues that has been raised around this discussion of the shortage is the suggestion that there really are enough people out there who want to be and are nurses, but for a whole host of reasons they have made a decision to either leave the field altogether or to leave the field and engage in it on a part-time, temporary basis. Some have made the decision to leave because by their own personal, nursing standards, they don't think they could provide the kind of care they think their patients deserve. I have to believe that in the business you are engaged in, that is a very real problem that nurses confront on an hourly basis. You have a sense of this person, their conditions, and what should be happening, and that may not be consistent with the dictates of the facility in which you are working.

So it is a little bit like the teaching profession. We have a huge amount of people come in and they immediately leave because it doesn't reinforce what they thought they would be able to do in nursing. We have a significant number of people who want to enter the profession from other areas, but when they really engage in it, they realize it is not competitive with other alternatives. It may be demanding on their personal lives or family.

I wonder what your comments are on that, that this is really about an underutilization of the talent pool that already exists, before we get to what the real shortage would be? The conditions and the standards to some extent have caused people who would like to be in the field to leave. Do either one of you want to respond to that?

Ms. Tompkins. I think you make a very valid point, but I think that alludes to what you were just saying. We need to make the career more desirable. I mean these people didn't go into nursing with the intention of quitting or leaving the profession a couple years afterwards. You know, my unit is one of a kind, I think. I don't think that is happening across the country. It is clear that it is not. I think we need to improve the conditions, as you were just saying.

Nurses need more support. We are completely strapped at the bedside and don't have enough time to do anything. We did not go into nursing to know that at the end of the day we just provided adequate care. That is not why we are there. We don't do it because of the money, but it is a factor. A nurse's salary is not competitive for the level of work they do and the expertise that is needed.

Ms. Velazquez. Could you refresh the point for me? I was distracted for a moment.

Mr. Miller. We have a talent pool that is trained, educated, and who in many cases has already worked in the profession. They made a decision to leave. How do you get those people back in, because they are an immediate qualified talent pool?

Ms. Velazquez. Exactly. You know, as I was discussing this over the weekend with some other colleagues, it struck us that, obviously, nurses are leaving the profession because the environment that we work in, for lack of a better phrase, can be toxic at times. The constraints that are put upon you in terms of hours of paperwork, which may not seem a lot, are a tremendous amount. I routinely stay over my 12-hour shift a minimum of a half an hour just to get all of my assessments into the computer to make sure that this database is filled out or this floor sheet is filled out.

The reason why I choose to stay over is because I would rather spend those 12 hours with my patient. So I would rather sacrifice the time when I don't have to be attending to them, because that is the way I want to be a nurse.

Mr. Miller. I am running out of time here, but you know, the points that you and others in the nursing profession raised are interesting. I had an opportunity to have dinner a couple weeks ago with one of the CEOs of the largest or second largest health care provider in the Nation. And he said if you really want to know what is being put at risk with the current arrangements that we have, he said go see the Institute of Medicine studies and you will start to understand that this has a very, very real impact on the quality of care. I am sure he has battled a number of these staffing changes and he has done some progressive things.

But to suggest this can be ignored and no harm is being done, I went and got the Institute of Medicine studies. The studies laid out a pretty frightening blueprint of what we can expect in terms of the quality of care if we don't start to address this very immediate problem and get some continuity and consistency in staffing levels and capabilities on a regular basis rather, than running around ad hoc at the beginning of a shift and trying to see if you can put people in place or not. That is what is happening in many health facilities across the country, both rural and urban.

I thank you, Mr. Chairman, for holding the hearing. I hope the Committee will have a chance to address it.

Chairman Boehner. Sue, did you want to make a point?

Mrs. Kelly. I would like to simply say that I believe there are things that we as legislators can do. There are many people who are in ancillary positions in the medical profession. We need to encourage those people to continue to upgrade their education. We can do that through the bills that are available by offering scholarships. We have LPNs. We have CNAs. We need to put them on a career ladder that promotes them. We need to raise the RNs that are there into positions so they will be professors of nursing. These are people that we really need to address and this is something we can do legislatively.

This is in the bill that I am trying to get through, the Need Act. We have got an expanded loan repayment program that would allow people who are in nursing homes, people who are in home health agencies, people who are in public health departments and managed health care centers to be able to participate in these programs. Let nursing start in some of these outer areas and bring them up full into the nursing profession as RNs. These are natural places for reservoirs of people that we can naturally bring into the nursing profession.

The Bridge to Practice program that I have in the bill is an incentive for nurses to come back into the profession. Currently there are 15 to 20 nurses that aren't practicing. If we bring them back in, that is pretty easy. It is not difficult. It doesn't cost a lot to get your recertification in most States. But what you do need is mentoring. We need to get the money into the hospitals so those nurses can be mentored in the new techniques and the new drugs and so forth.

These are things that I think we can do. There is more. But I just wanted to point out a couple of things. I think we should also establish a commission to study this nursing shortage to try to address the best and most rapid ways that we can get nurses into the field.

Thank you, Mr. Chairman, for letting me speak because I think it is very important that we reach out to people who are currently in these ancillary professions and try to scoop them up and bring them in.

Mr. Miller. Might I respond Mr. Chairman?

I couldn't agree with you more. But if the basic profession that they are going into has working conditions that drive them out of it, we have a problem. After we take the LPN and make them an RN, and they look around and say I don't want to work here because this is inconsistent with patient care, or family life, we have the same problem. They come in and leave.

We want them to come in and stay, because it is a profession that encourages that. We have 100 programs to get people into the teaching profession. They look at it a year-and-a-half later and say I am out.

Mrs. Kelly. Mr. Miller, that is why I feel strongly we have to do everything we can to provide the loan program for these people to bring them back in. We also need to do the mentoring program to bring them back in. Nursing is a wonderful profession. You have heard the commitment of the people who are here. They are deeply committed to helping people. Nurses want to do that. But we need to help the hospitals be able to pay them a really good wage.

We also need to encourage the hospitals to offer exactly what these young women who are testifying with us today are comfortable with, and that is flexible hours. Reduce the paperwork so hospitals don't have to pay overtime because nurses want to spend the time with their patients. We can do that. This is something we can do at a legislative level. We can help the hospitals do that by putting the incentives in place to do that. We need to do everything we can to encourage the nurses to stay in the profession. I agree with you.

Mrs. McCarthy. I want to follow up on that. You know, going back 30 years ago in nursing, number one, there was never such a thing as having a full staff. And God forbid you should have one or two nurses that were on the floor; we were shipped out to another floor that was shorted.

But going back to what you were saying as far as keeping nurses there. If we can train people so there are enough support staff on every single level that will retain the nurses that are in the field, because then they have the help.

Following through on that, there are ideas out there that were working 30 years ago. The hospitals in my community have taken those that are nurses' aides and those that are already working in the hospital and upgrading them. In other words, they are getting a nursing career in the hospital, working with one of the universities.

Now, a lot more hospitals would do that, but they don't have the finances to do it. But these are things that we can take a look at. When Melissa talked about staying a half hour longer, I think she is probably cutting it quite short, because when I worked as a nurse I did stay at least a half hour to 45 minutes longer to do my report work and everything else like that. It has changed tremendously.

We certainly have done an awful lot to make sure there is not fraud and abuse as far as payments for reimbursement to Medicare. But I will be very honest with you, in every aspect of our health care industry today, we are treating those that are giving the health care, whether it is the hospitals, or the nursing homes, like criminals by having them prove that they didn't make a mistake filling a form out. And I think we have to really look at that, because we didn't go into nursing to spend a heck of a lot of time on forms. We know how important nurses' notes are and everything else like that, but it is way beyond that today, and we have to look at those types of issues.

All of those combinations together will bring people into nursing, because people are still going to want to go into nursing. We need to retain them and make sure they stay, the same as what we should be doing for our teachers.

Chairman Boehner. Mr. Osborne, any questions?

Mr. Osborne. Thank you, Mr. Chairman. I just wanted to make a couple of observations.

You mentioned the paperwork. As I have talked to nurses in my area, those who have been around for awhile, they maintain they had spent 85 percent of their time nursing and 15 percent filling out forms. Now it is 50-50, particularly where there are high concentrations of Medicare, as there are in my district. So this is one thing that strikes me the government can certainly get active in, because apparently there is a duplication of forms that really is needless.

The other thing I would like to ask you about is rural areas. You often hear about a small town losing its doctor; but probably as prevalent is loss of health care, because they have lost one or two nurses. We can't have health care without nursing and support. And so in an area that is isolated, if you lose two or three nurses, or lose your hospital, you are driving 50 to 60 miles to the next hospital.

This may not be your area of expertise, but I wonder if anybody has any thoughts about rural health care particularly?

Mrs. Kelly. Mr. Osborne, I just want to say, a lot of people don't realize that when a nurse makes notes in a chart for a patient, or when anyone who is a medical professional makes notes in a chart for a patient, those notes become a legal document and you are not allowed to change them. You can't scratch out and you can't white out. When you make a note about a patient, it has to be accurate. And that is one of the reasons why these nurses take so much time, because they know they must do it right. They have to get it right the first time.

Secondly in the bill that we are sponsoring, because we are offering scholarships, we are asking people to commit to at least 2 years service especially in underserved rural areas. So we hope that will help deal with that problem.

It is a huge problem. We don't want to see the hospitals, especially rural hospitals, go under because they have no nurses. In the area where I live, in one county we had four hospitals. We now have one because the other three have closed down. There is a lack of available nursing and lack of support. The people have to drive for miles. Now we have to use helicopters to Medistat people to the hospital in case of an accident. So it is a very real problem and I thank you for bringing it up.

Mr. Osborne. Thank you, Mr. Chairman. I have no further questions.

Chairman Boehner. Chair recognizes the gentleman from Massachusetts, Mr. Tierney.

Mr. Tierney. Thank you. I just want to follow up a little bit. I want to thank you first of all for your testimony and for your legislation, but I wanted to follow up.

About a minute ago we were having a little colloquy back and forth between the Members about loans and mentoring, which I think are obviously worth pursuing. I think that is a different focus on the issue of forced overtime and understaffing, and I don't believe that loans and mentoring are going to really solve that issue. And I wanted to ask Ms. Tompkins and Ms. Velazquez if I am right on that or am I wrong on that?

Ms. Velazquez. Loans and mentoring programs certainly have their place in the issue, and as we were discussing earlier, the environment can truly be toxic. One of the things that happens quite frequently is the rise in patient care or patient-to-nurse ratios. For example, I had a colleague of mine share a story with me about a friend of hers who is a registered nurse at a children's hospital. The day shift was just fine, and they had 16 patients with adequate staffing. But on the night shift they only had 2 nurses to cover all 16 of those patients.

Now, whether or not you have ancillary support in terms of LPNs or other kinds of aides, 16 children aren't getting the care that they deserve. And I caution about legislating patient care ratios because I think there is a harm in that becoming, the ceiling around the floor, so to speak. If I say, okay in ICU there should be one nurse for every two patients, then that is going to become the rule, rather than having a little more flexibility and have nurses taking back the judgment on what it takes to run a clinical setting.

Ms. Tompkins. I just want to add something. I think we made it very clear that we need to fix the current situation for those people that are already in practice. But I think we shouldn't lose sight of very important things such as scholarships and loans. I can speak from personal experience. I went to nursing school through a scholarship program through a hospital. And I wasn't one of those people that knew from age 5 that I wanted to be a nurse. So it was that opportunity that probably swayed me more in that direction versus maybe going another career route.

Mr. Tierney. I am not ignoring our Members, but I can see them any time. But from your own personal experiences, how much involvement do the nurses have with hospital management in actually determining and establishing policy regarding the nurses?

Ms. Tompkins. I think that really depends on the institution.

Mr. Tierney. What is your personal experience?

Ms. Tompkins. As I said earlier, we do self-governance in my unit. We have a lot of staff-run committees. It tends to be a somewhat open forum for grievances, and things you want to bring up. I mean it is definitely doable. I have never felt as if I couldn't get my point across.

Mr. Tierney. It applies directly to staffing issues. Have you had success there?

Ms. Tompkins. I have had my patient care director have to go to bat for us at higher levels concerning vacancy rates, things like that.

Mr. Tierney. Thank you.

Ms. Velazquez. Actually, prior to last fall, there was a staff nurse representation on the majority of the committees at the hospital. And that is one of the things we fought for in the contract negotiations that occurred last fall. And quite honestly, I personally haven't seen any changes that have truly addressed some of the issues that we were most concerned about. As I mentioned before, we did have some changes in scheduling, but you know, committees, present company excluded, tend to work a little slowly. And I am sure there are changes in the works, but I have yet to see them actually implemented in the workplace.

Mr. Tierney. Thank you, Mr. Chairman. So you can move quickly, I yield back the balance of my time.

Chairman Boehner. Thank you, Mr. Tierney. The gentlelady from Illinois, Mrs. Biggert.

Mrs. Biggert. Thank you, Mr. Chairman.

I have a question for Congresswoman Kelly. In the Need Act, you talk about the public awareness campaigns and the multimedia outreach. Is this something that would be done in the schools or is this just kind of public service addresses to tout nursing careers?

Mrs. Kelly. It is all part of nurse recruitment, and we would like to have about $5 million for a national campaign. That would be on TV, radio, or whatever they feel is the best way to recruit nurses. The other part of it would be another $5 million in States so they can get into places like high schools and even grade schools where kids start thinking about who they admire in society and what those people are actually doing. Exposing young people to seeing the value of nursing is a really valuable way to recruit people.

So we are really leaving it up to both the national and the State levels to decide how they want to spend this money. We haven't really lined it out. It is fairly flexible because you approach different areas in different ways.

There are area health centers that we really want to help develop as models of excellence for school nurses and public health nurses and perinatal nurses. There are also nurse outreach grants. I mean we are doing a lot to try to bring in health care providers from other areas and get the communities to partner in on this, to bring in a network of help to try to not only build the quantity of nurses that are there, but also create a support network for them and to help them retain them.

We have also incorporated scholarships for people who are in the disadvantaged programs. We want people from disadvantaged backgrounds to have a shot at the pie also. So we have included that in.

Mrs. Biggert. I don't know if you would know this or if this is a question for the next panel. The schools that have nursing are trying to recruit nurses, but do more people apply for the nursing school than are accepted? Maybe some don't have the qualifications or have the grades to get into nursing school, or is it just that everyone is taken in that applies?

Mrs. Kelly. In the nursing schools that I have dealt with, Mrs. Biggert, they tell me that when they feel that a student is capable, even if the student hasn't performed perhaps at a certain level because of their English ability for example, they will work with those students to try to help them.

Duchess Community College in my area has an excellent program to try to mentor people into nursing, and they have a superb nursing school there. There are a number of people, at least in my area, through the community colleges as well as the regular colleges that have very good programs. I am sure in Ms. McCarthy's area down in New York City, we have nursing schools teaching to the Ph.D. Level. So we are doing everything to mentor and push those people along.

Mrs. McCarthy. And we can follow through with that, but still not enough people are applying to the schools themselves, and that is a big problem. And as our colleague has said, we have to start putting out the positive aspects of nursing. You know in my opinion, I think all of us will agree it is the best profession to go into. But over the last several years, you are only hearing the negative part of it. But this is something that we have to work on on several fronts. Obviously the pay is a problem, but all of us have said we didn't go into nursing because of the money. And you will never get the kind of money, in my opinion that nurses deserve for the work that they do. But you still have to be competitive.

I have been meeting with nurses and hospital administrators for the last several years in roundtable discussions, and the nurses have now become more active in going to the schools. But, this is kids; they ask, what kind of money do you make? I mean that is a question that they ask. And when you tell them what your salary is and that you are talking about working holidays, weekends, 24-hour shifts as far as it has to be covered, they ask if you are nuts? Who in their right mind would do that?

But aside from that, there are still many, many people changing careers. Those coming out of the service, our police officers that come out and still are on the fairly young side becoming a health care professional. And certainly there is a shortage of nursing. But let me say there is a shortage in every aspect of health care. You know, whether it is your occupational therapist, whether it is your speech therapist, this is a team effort. And that is important to bring out.

We talk about the shortage of nursing because we are the ones there by the bedside first. But it is not going to do any good if a physical therapist isn't there to work with the stroke patient. It isn't going to do any good if a speech therapist is not there to teach that patient how to speak again.

So we have a long way to go to look and try to get everybody around here to see that we have to all be together. Any kind of health care is a team effort.

Mrs. Biggert. Thank you. Thank you, Mr. Chairman.

Chairman Boehner. The Chair recognizes the gentlelady from California, Ms. Woolsey.

Ms. Woolsey. First of all, I want all the nurses to know that you are at the top of my list of heroes, and it makes it clear to me why I consider these two colleagues of mine and Lois Capps to be so special. I have always held you in high regard. It is that nurse in you that I think works for me, and thank you, all of you, for what you do.

When Ms. Velazquez was speaking, something occurred to me that I just have to share. And that is, on the 11th of September, while a lot of us were dithering around, I will speak for myself, not knowing what I should be doing and what I could do, you had hands-on activities. You were needed. You knew what your role was. And that had to make you feel better than the rest of us in this country who cared so much and felt useless.

So thank you for what you did. It makes me realize when you don't have any control if you are doing something it makes a difference. Thank you.

I have a question for Sue Kelly and it is about your Need Act. You have another piece of legislation that you authored with Lois Capps. Could we bring those two together, because there are 100 cosponsors on the other one? Which one better addresses salaries and patient nurse ratios and training facilities? I mean there is so much we need to be dealing with. I think we should blend those.

Mrs. Kelly. Well, what happened on the Kelly-Capps bill, when Lois and I originally drafted that bill, we worked hard to get that bill where we thought it would address all of the needs. And then after we offered that bill, I realize that there were some further things that we needed to do, and that is what this other bill is about. That is the career ladder I am talking about. You heard Ms. McCarthy speak about the fact that medical care and hospital care is a team effort. It is that team we can draw from to bring people along to enlarge the nursing pool.

Ms. Woolsey. Let me reclaim my time, just a minute, Sue. Can we blend those two because you have 100 cosponsors? You have people loving that first one. We need the whole thing.

Mrs. Kelly. I think we certainly should look at that. I am hopeful we can do something like that. But I just want to make sure we are doing the things that I had not thought of with that first bill.

Ms. Woolsey. Thank you. I am going to talk to Congresswoman McCarthy about training. I have legislation called Go Girl, because young girls don't get involved in technology. About 30 years ago we had good ideas for nursing, but nursing is becoming highly technical. What are we doing to ensure that young girls who want to be nurses start at very early ages getting ready to become nurses in this technological world we live in? How do we get the nurses' aides capable to be in the technological world?

Mrs. McCarthy. I certainly want my colleagues to address this. Nursing today is totally different. The high-tech aspect of nursing care has gone up. That goes back to working with women in grade school, middle school, and high school to go onto computers, the sciences and math. A lot of people don't realize how much science and math you need to go to nursing school. I mean these are all areas that are very important.

And with that being said, again, we have many solutions. If we could have a comprehensive education bill, we should have a health care bill dealing with every single aspect of the health care crisis that we are facing, including getting nurses.

Also don't forget the hospitals. Good hospitals have to put any moneys they make, which God knows they don't make any, into the infrastructure and the equipment that they need. So they have always operated on a shoestring the majority of the time. If you want a good health care system, then you have to make sure our hospitals are in good financial condition so they get the equipment and the technology that they need on every single level, and hire those that work with all of that technology. So it is ongoing.

These are the things that this Congress and we will have to face, because we are dealing with a Band-Aid here and a Band-Aid here and a Band-Aid there. We really do triage the whole system, and we are not going to be any better 5 or 10 years down the road.

Ms. Woolsey. Thank you.

Chairman Boehner. The Chair recognizes the gentleman from Pennsylvania, Mr. Greenwood.

Mr. Greenwood. I am sorry I wasn't here for your opening statements. I was at a briefing on the disaster at the Commerce Department. And I am sorry if you covered this in your opening statements, but the question has to do with attracting males into nursing.

I don't know what the statistics are, but we all know that nursing was a female-dominated career since its inception and I assume it still is a female-dominated profession. However, it seems to me from my layman's casual observation that more and more males have been attracted to nursing. It was always embarrassing to me when I would meet somebody and I asked them, as we do, Hi, what do you do? "I am a male nurse." Well, you didn't need to tell me the first thing. I noticed that. But it was almost this sort of need to establish maleness, even though I am in this female-dominated profession. And I think we can recall how we used to have stewardesses in airplanes and we changed the name to make it gender neutral and realized that it was a profession that welcomed males as well as females.

So my questions are what do we know about the percentage of nurses who are males? What is being done to attract males into the profession? Because if we have this shortage and we are not really aggressively pursuing half of the eligible population, it seems that would be a rich source of new recruits.

I am trying to figure out a way to say this that is somehow not politically incorrect, but it seems to me that the term "nurse" is so identified with feminine and gender that I can imagine if you went to a group of 16- and 17-year-old boys and said, "You know there is a great career path for you as a nurse," that their reaction might be, "That is for girls, isn't it?" I wonder if the terminology needs to be changed, because that word "nurse" is so identified with females, to help draw males in?

So what can you tell me about the percentage of nurses that are males? Is that going up or down, and are there aggressive efforts to attract males? And did I say something politically incorrect?

Mrs. McCarthy. Yes. We don't want to change "nurses." The percentage of males going into nursing in 2000 was about 6 percent. But again, you also don't see that many males going into teaching, and teaching was basically a female dominated field as far as that goes.

Mr. Greenwood. I bet it is way over 6 percent in the teaching profession.

Mrs. McCarthy. It has increased in teaching more so than nursing. We have looked at our veterans coming out of the service. We have looked at fire and police officers that have gone out of their particular field to go into the health care fields; I am saying health care fields because there are so many aspects.

When my son needed care, Kevin is 6'4 and 240 pounds, every time he had to go into the hospital, we would try to get male nurses to take care of him, only because of his size. And I am talking about the private duty aspect of taking care of him, because when he goes for an operation of any kind, he is usually 100 percent incapacitated, so it would take two or three nurses to take care of him.

The Committee should meet some of these male nurses. These are big burly guys, most of whom were firemen or police officers. Why did they go into those particular professions? Look at what caring people firemen and policemen are. Can we do more? Absolutely. We are working on that and they might have more information on that.

Ms. Tompkins. I just have one thing I wanted to add. I believe education is extremely important and there has been a huge step-up in efforts to really educate the younger generations. We may not necessarily be able to fix that old stigma of nursing being for girls, but I know they did a summer camp for nursing for seventh and eighth graders. And in a graduate class I took a couple of semesters ago, we did a book that will be published for that adolescent age group that educated them on exactly what it is nurses do. We are trying to get rid of that picture of the white dress and walking around with a bedpan, because that is not how it is anymore. We tried to give them a picture of the technical aspects and the cool things that we do.

Mr. Greenwood. My time has expired. I am sure that this will be politically incorrect, but it occurs to me, and Mrs. McCarthy was very adamant, that nomenclature matters. When you have a profession and a word that simultaneously means both a health care provider and to breast-feed a baby, you might think about how that impacts on attracting men into the profession.

Chairman Boehner. The gentleman's time has expired. There is no other Member of Congress more discreet than the gentleman from Pennsylvania, and usually very tactful. Was, anyway.

The Chair recognizes the gentleman from Virginia, Mr. Scott.

Mr. Scott. Thank you, Mr. Chairman. I thank you for addressing this issue on a timely basis before it gets much worse. I just have a couple of questions.

I wanted to ask Ms. Tompkins, on the self-governing or staffing committees, do you do that on your own time or do you have to volunteer for that? Is it part of your job.

Ms. Tompkins. No, it is not required. We do try to encourage everyone to get involved on committees, and it is on your own time.

Mr. Scott. It is on your own time? It is not on paid time?

Ms. Tompkins. We get paid, but it is not during your usual 12-hour shift. We have to come in on our days off to participate.

Mr. Scott. Are any of the nurses involved in that part of unions?

Ms. Tompkins. No.

Mr. Scott. I think we all agree that salaries have to go up. Can I ask Representative McCarthy or Representative Kelly exactly how, the legislation that you are proposing would actually increase salaries? If you put more money into Medicare or Medicaid, it could go any kind of way. How do we make sure that the initiatives we take will actually result in increased salaries?

Mrs. McCarthy. Well, I am hearing Sue Kelly on the side. I know my legislation will not increase salaries, but we are hoping to make the health care systems, whether it is Medicare reimbursements or forgiving student loans for those that go into nursing, look at that. And then hopefully have the moneys available for the hospitals. Maybe the Federal Government can do that.

Mr. Scott. I don't want to be cynical, but if you give the hospitals more money that doesn't necessarily translate into higher nurses' salaries.

Mrs. McCarthy. If they want to keep their nurses it does. Every hospital association and every hospital CEO that I have talked to, maybe Long Island is unique, but I really do not think so, want to pay their nurses more. They would love to pay their nurses more. But they are working under constraints as much as any other business to stay afloat.

You have to understand, we want to certainly pay our nurses the most money that we possibly can. But when you have a new technology that comes out, whether it is an MRI or the newest technique instead of having a barium enema, they have to invest in that because that is good for the patient.

Mr. Scott. That makes my point. What can we do to make sure that the money actually gets to nurse salaries?

Mrs. McCarthy. If I say this, my staff will absolutely kill me, because I have been talking about it for 2 years. Every time I mention the word they tell me I you can't say that. I will say it.

We subsidize our farmers. We subsidize many things in the government. And if you truly want good nurses, and if you truly want good teachers, then I think the Federal Government has a role in it. Of course, every time you mention "subsidizing" something around here there are heart attacks all over the place. The truth is if we don't start looking at salaries realistically for the worth of the nurses and our teachers, you are not going to get more and more young people, or anyone, to go into those fields. That is the bottom line.

Mr. Scott. Representative Kelly?

Mrs. Kelly. Well, part of it is that the legislation that I have is in scholarships directed to nurses only. They are directed just for nurse core scholarship programs, to bring ancillary people into the nursing profession and to bring people who are RNs back into the nursing profession.

One of the other things that I think you may want to explore, is the part of the problem that has to do with the HCFA rules, or whatever they are calling the agency today that governs hospitals. Any moneys that go to the hospitals need some flexibility, because as we all know, hospitals all over the Nation are trying to get into metropolitan statistic districts so they can pay their nurses at a higher level, so that they don't have a problem getting nurses to come in and work.

If we were able to address that hospital problem through a change in the HCFA rules, that would help bring nurses in, I think. But in the bills that I have, the scholarships are directed to bringing people in and retaining nurses specifically. The money doesn't go to hospitals.

Ms. Velazquez. If I may add a point in here, please. I so appreciate everybody wanting to pay attention to salaries, because that is a factor, but the work environment is what I feel is truly important here. You can throw as much money as you want to me and my colleagues, but if I go home at the end of the day, losing a patient because I didn't have the time to take care of them, or having any of my colleagues put in the position where they weren't able to do the best job that they could, there is not enough money in this country to make up for that feeling.

As we said before, nursing is a calling, and not everybody can do it. And I would hate to bring up the male perspective here, but there is a reason why nurses are mostly women. I am sorry.

Chairman Boehner. No, go right ahead. Please. We have an open forum here.

Ms. Velazquez. But on a more political note, regarding issues of mandatory overtime, patient care ratios, and staff nurses having a say on hospital committees it is my understanding JCO requires nurses being involved on these committees. But many times the nurse involvement is nurse managers and upper level nursing positions. Those are the kinds of issues that affect nurses all over this country, and until you fix the working environment, really the salary issue is kind of moot.

Chairman Boehner. The Chair recognizes the gentlelady from Hawaii, Mrs. Mink.

Mrs. Mink. Thank you very much, Mr. Chairman. Thank you for calling these hearings on the nursing shortage issue. It is a terribly important question that we have delayed too long to address in this Committee. Now, I want to compliment my two colleagues of the House for their thoughtful contributions to this discussion, and certainly our two other panelists who have a day-to-day contact with this issue.

It is a very easy problem, it seems to me, if we have the will to do something about it. And we have some outstanding legislation that is before the Congress. We ought to pass it with dispatch. I don't think that there is a profession in our communities that is more highly regarded, more highly respected than the nursing profession. We all deal with the tremendous reliance that we have if someone becomes ill and we totally put ourselves at the disposal of the nurses and the physicians in a hospital situation. And we depend upon them. We depend upon not only their caring spirit, but also the professionalism that they bring to the hospital environment. So it is criminal for us not to take hold of the pending legislation and do something about it.

If it is a recruitment problem, a retention problem, a retraining problem, we ought to deal with it immediately and try to bring those who are interested in the profession into it and train them, and those that have left, bring them back and retrain them. It seems to me it is obvious that we have the power and authority to do that in the Congress.

On the other hand, there are other perspectives of this issue that are very troubling and probably outside of the parameters of this Committee. As I understand it, one of the reasons for this crunch in the hospitals reducing the numbers of nursing staff is because of the diminishing reimbursements under the Medicare/Medicaid system. And that is our responsibility indirectly, but not in this Committee. And so we ought to put pressure on the Ways and Means and other Committees that have jurisdiction in this situation and take a look at the impact of diminishing reimbursements to the hospitals and the impact on quality of health care, to squeeze out the staffing that a hospital needs to have.

I understand from some of the testimony that we have received, that California has taken a very bold step forward by establishing standards for hospitals in terms of the number of licensed, credentialed, registered nurses that must be hired for each of those departments. And I think that that is the way to go; maybe too far for the Congress to go, but certainly something that we ought to encourage.

As for my colleague Mr. Scott's concern that if we did put more money into Medicare and Medicaid, that wouldn't go to nurses, we can certainly earmark it and say if we are going to reimburse Medicare patients at a higher level, that this amount be reserved for staffing so that the quality of care in the hospitals can be improved.

I think this effort requires a comprehensive look by a number of Committees in the Congress, and certainly under the leadership of Congresswomen Kelly and McCarthy we can push the bills that are in this Committee and get them moving forward and encourage people to enter the profession.

In my own State, as I looked at the statistics I find that there are huge numbers of registered nurses, certified, who have left the profession because of the work environment that they find difficult to deal with. So we have to look at the overtime questions and some of those other things, and hopefully can get these nurses to return back to their profession.

So I applaud all of you in your contributions to this discussion and hope that this Committee will speedily act on our portions of this issue. Thank you very much, Mr. Chairman.

Chairman Boehner. The Chair recognizes the gentlelady from California, Ms. Solis.

Ms. Solis. Thank you, Mr. Chairman. And I want to applaud you for having this hearing. I think this is probably one of the most important issues that, as a new freshman when I came in, I wanted to see some reform made in. Coming from California, we worked on various pieces of legislation to try to address the abuses that go on throughout the system in terms of health care delivery, but particularly the whole issue of forced overtime.

The fact that many nurses in our districts, and particularly in mine, have lost their jobs because they refused, after 12 hours, or after maybe a shift or more, and said, you know, I am putting myself at risk and my patient at risk, and the bottom line is I am not prepared to do that.

I haven't heard anyone here talk about that in particular. But that is something that is really happening not just in my community, but also across the country. And I would be interested to hear about some of your ideas regarding the use of voluntary overtime and the fact that perhaps there should be some protections in place for nurses who are the ones who are really making the decisions about the quality of care that a patient receives; you know, when that ends and when it begins.

I would like to hear some of your thoughts on that.

Ms. Tompkins. I am not sure I really understand the question.

Ms. Solis. Well, part of it is, you in particular talked about being able to self-schedule yourself. In many of the hospitals and care facilities I represent, they don't have the luxury of doing that. So how does that work, then? Have you ever been in a particular situation where maybe you were asked to work forced overtime, and how did that affect your ability to provide health care?

Ms. Tompkins. I can't speak to that. I have never been asked to work mandatory overtime. I have been asked at the end of a 12-hour shift if I would stay for a 16-hour shift. That happens frequently. But it is nothing that is forced upon us.

Ms. Solis. Would you say that affects your ability to provide the same level of care?

Ms. Tompkins. Sure, 12 hours is a very long day in itself. When you add 4 more hours on top of this when you weren't planning to be there, sure it does.

Ms. Solis. Is that something that has been brought to the attention of your particular facility? Is that being addressed in any way?

Ms. Tompkins. It is just part of the entire shortage that is going on. This is happening in all of the units. It is being addressed.

Ms. Solis. Addressed in your particular setting? I would like to hear from the other witness. Ms. Velazquez, what is your take on this?

Ms. Velazquez. As I said before, I am an officer of the union at the hospital where I work. One of the huge issues that we had with our last contract negotiation was that of mandatory overtime. It was brought out that there were specific units that were affected by mandatory overtime. And our bottom line was no mandatory overtime, because mandatory overtime is kind of a Band-Aid to put the fix on short staffing. Okay, we can't find any nurses so, hey, we are going to make you stay.

That is thoroughly unacceptable. Now, obviously our bottom line was no mandatory overtime. What we did end up achieving are significant limitations on mandatory overtime in those specific units. I can remember that the cath lab was one of them. I am sorry, I am a little foggy on the actual details without having the contract in front of me as to who had less strict limitations on mandatory overtime than we did for the rest of the hospital. But there is also a mandatory overtime bonus that was added.

We are really not about the money. If I am working a 12-hour shift, so to speak, and I need to go home and get my daughter, get her off to school, what do I care if I am making an extra $10 an hour for that 3- or 4-hour period?

As I was saying, the restrictions that we ended up achieving in the rest of the hospital were something to the effect of a limit of three 4-hour periods within a 6-week schedule. And there are some guidelines to actually phase that out, to no mandatory overtime over a period of time. So we were able to achieve some language in the contract with reference to that. But, as I said, our stance is no mandatory overtime. But hopefully one day we will be able to get to that point.

Ms. Solis. I have just a last question on the education and media campaign to try to recruit more individuals into this career. I find that there isn't adequate outreach being done to particular populations. I am talking about the diversity of our communities, in particular the Hispanic community.

We have very few individuals who actually go into the career. So it isn't just enough to say that we are going to provide with you financial aid and assistance, but there also have to be mentors and role models who represent that community who will be made available. Particularly folks, who can share that kind of expertise, and a long-term commitment to make sure that these students, once they are eventually brought into the institutions, succeed and that retention levels are there.

Perhaps the Congresswoman can address if there is any notion about providing not just the recruitment and the media in the bill, but the retention aspect of what needs to be done to keep those students in these curricular programs.

Mrs. Kelly. Yes. Thank you. The bill does address disadvantaged students. It does address keeping students in school, helping them get through the programs, doing what has to be done to do pre-entry preparation and then work on retention once they are in school.

But I would agree with you that America is a wonderfully diverse population. Our unity is born from our willingness to recognize that diversity and work with each other. It is extremely important that any scholarship be given to anyone who is interested in the field. And in the outreach, it is my hope that we will be able to include language that will especially go to reach certain discrete populations that are not as heavily represented. And we need them. We need them for a number of reasons. We need them for their multilingual ability.

One of the problems that I experienced when I was working in the emergency room was that we would have people come in and they would be speaking a language that we could not identify immediately. We would have to try to think through from the syllables that were being said, what language they were speaking and then try to get someone down to interpret for us.

It is very important that we acknowledge and direct our efforts toward that diversity, and I thank you for bringing it up.

Chairman Boehner. Mr. Andrews.

Mr. Andrews. Thank you, Mr. Chairman. I want to thank you and the Full Committee for inviting Mr. George Lynn, who is a resident of New Jersey and one of our health care leaders who is going to appear on the second panel. And I welcome him.

I also want to say for the record how proud we are of our New Jersey nurses and all of our health care professionals who played a very significant role in dealing with the events of 2 weeks ago in New York. Sadly, most of the nurses and health care professionals that I talked to said that they were shocked, because they were prepared to receive thousands of casualties as the day went on and did not receive them because the death toll was so high. So we in New Jersey are particularly proud of our men and women in the health care professions.

The issue I wanted to raise was about long-term care and that the number of Americans over the age of 70 will more than double in the next two decades. And that means that our resources for long-term care are wholly inadequate today and will be taxed and tested greatly in the future.

Now, nurses are a part, of course, of the health care team, the full team of people that deals with the health care needs of patients. The GAO recently concluded that we are going to need 800,000 additional nurses' aides, many of which will be in long-term care in the next 7 years. I wonder what the panel thinks we should do about that problem? I realize that it is a broader question than your previous testimony. But my understanding is nurses are committed to the health care needs of the patients in a holistic sense, not simply the needs of nurses as caregivers.

I want to know what you think we ought to do to encourage people to go into this profession and be trained for it and be prepared to help meet that need? I would be happy to hear from any of panelists that would care to answer.

Ms. Velazquez. I think I will stick with what I was maintaining earlier. The work environment needs to change. You just can't attract people into a profession when they are treated as poorly as they are in some cases, especially in long-term care. And once we can get that changed, the attitude of the profession is going to change, and the attraction into the profession will follow that.

Mr. Andrews. Ms. Velazquez, I think your point talks to the wisdom of the bill that Ms. Kelly and Ms. McCarthy have put forward, talking about Medicaid reimbursements.

In my State, New Jersey, on the average, Medicaid reimbursements are about $20 less a day then the cost of taking care of the patient. Our facilities are losing money every day by taking care of Medicaid patients. So the option of raising the pay of anyone, and therefore helping to improve the working conditions of anyone, is not on the table. I think the wisdom of the legislation before us is its insistence on raising those reimbursement rates, which is why I am happy to support it.

Mrs. McCarthy. I think that as far as the amount of nurses' aides that we are going to have, certainly there will always be people that will go into being nurses' aides, because they might look at it as a way of moving up.

I will share an experience with you. When I graduated from nursing school, my first night in ICU in charge, it was two nurses' aides and I. Thank God that they were there, because I have to tell you that they probably had 20 years' experience. We had one heck of a night, and I thought that I was prepared, as all new nurses do. They got me through the night.

There are many that want to stay in that particular level because they love it, because they want to stay by the bedside; the same as you will hear so many nurses say, well, I don't want to move up because I want to be a bedside nurse. So you will see a lot of people that are coming into the field to be the nurses' aides. But, again with technology it is making the education levels even for a nurse technician higher. Hospitals now take nurses' aides and move them up into that category on what they can do.

I think you will see people going into those fields. Let's face it; as we have more and more immigrants coming into this country, this is how a lot of them come into the hospital health care system, to improve their own education and to improve the opportunity for them to move up. We have to make sure that those opportunities are there.

What you had also said is nurses are going to be older, and they are. If I had stayed in nursing, I would be 57 years old, and I certainly had no intentions of ever leaving nursing.

Mr. Andrews. We are glad that you did.

Mrs. McCarthy. Sometimes I am glad that I did, too. Only because I don't think my back could take it. Because you have to realize, there comes a point, especially with nurses or nurses' aides or anyone in the health care field, when bodies can't take it.

I worked in ICU for many years, and I loved it. I was telling some of my colleagues earlier, I was proud. A few years ago, I could have lifted a 180- or 190-pound person. You can, because you have learned the techniques to do it. But as you get older, it gets a lot harder and you need someone to help you. There are techniques on how to do it, but there comes a point in your age when the will is there but the body is not. And I don't care how well you take care of yourself; the muscle tone is not the same. It is just part of the aging process.

Mr. Andrews. Thank you, Mr. Chairman.

Chairman Boehner. Thank you. Let me thank the witnesses, our two colleagues and our two nurses from the local area. Thank you for your testimony. And that concludes our first panel.

And we welcome the second panel to come forward.

Well, let's attempt to begin. I would like to yield to my colleague from California, Mr. McKeon, to introduce the gentlelady who will be our second witness today.

Mr. McKeon. Thank you, Mr. Chairman. It is my pleasure to be able to introduce to you today one of our witnesses.

Before I do, I would like to take a moment and say how very pleased I am that the Chairman has arranged for us to hold this hearing to learn more about this important issue. Florence Nightingale, who is remembered as a pioneer of nursing and a reformer of hospital sanitation methods, was often called the lady with a lamp because she believed that a nurse's care was never ceasing, night or day. She taught that nursing was a noble profession and she certainly made it so. Her influence has been far-reaching, as a caring nurse at one time or another has assisted countless people through the years. I am appreciative of the work that nurses do, work that is demanding, physically tiring, and insistent.

Let me now introduce to you a nurse from my district, Sue Albert, who is the Assistant Dean of Allied Health, College of the Canyons in Santa Clarita, California. Sue received her nursing license and her Bachelor's in Nursing from the University of California, Los Angeles. Later she received a Master's in Nursing, also from UCLA, and then a Master's in Health Care Administration from the University of LaVerne.

I commend Sue for her 13 years of service as a pediatric and a medical surgical staff nurse. This practical knowledge, along with her experience as a professor of nursing and her supervisory and management roles within the higher education community, will teach us much about the nursing field and the issues and problems we are currently facing.

I want to thank Sue, who came here a couple of weeks ago for this hearing when it was originally scheduled, and then due to the national tragedy we all experienced, returned home, and came back again today for this hearing. I appreciate you doing that, Sue, and look forward to hearing your testimony.

Chairman Boehner. Thank you, Mr. McKeon.

Our first witness today on the second panel is Ms. Mary Foley. She is President of the American Nurses Association, Washington, D.C. Our third guest is Ms. Carolyn

McCullough. She is a registered nurse and the national coordinator for the Service Employees International Union Nurse Alliance. We want to welcome you. Our fifth witness is Ms. Catherine Garner, Dean of the College of Nursing and Health Sciences at the University of Phoenix. We welcome you. Our sixth witness today is Mr. George Lynn, President and CEO, AtlantiCare. He will be testifying on behalf of the American Hospital Association.

I don't see my good friend from Georgia, so, Ms. Bartels, you won't get a very fancy introduction until we get it from Mr. Norwood. Our fourth witness Dr. Jean Bartels is the Chair of the School of Nursing at Georgia Southern University. We want to welcome you.

And with that, Ms. Foley, you may begin.

STATEMENT OF MARY FOLEY, RN, MS, PRESIDENT, AMERICAN NURSES ASSOCIATION, WASHINGTON, D.C.

Thank you and good afternoon. I am Mary Foley, and I am President of the American Nurses Association. I am proud to be a registered nurse. Our members of the ANA in 53 State and territorial associations include registered nurses who work and teach in all practice settings.

It is hard to find words to express the profound sorrow and compassion that I feel for those impacted by the unspeakable acts of September 11th. ANA is grateful to all of the heroes who immediately responded in this time of need, and they do renew my faith in what is good in our Nation.

On that fateful Tuesday, nurses were among the many who answered the call to provide emergency services. And you have heard two of their stories today. My written statement also contains an addendum with additional accounts from nurses who dropped everything to provide care to the victims and to the families.

Our affiliates in New York, Virginia, and D.C. Have told me that their phones have been overrun by thousands of offers of support from nurses, literally around the world. And I am not surprised. This overwhelming response is the norm for my profession, and we will be there to help in time of crisis.

We will always be here to help to prepare for the campaign against terrorism. We need to consider ways to make sure that more of America's civilian nurses are educated in the protocols for biological and chemical warfare and other weapons of mass destruction.

In addition, it is important to recognize that the activation of medical military units will increase pressure on the already strained nursing workforce back at home. Just as in the Gulf War, the current activation of our military, National Guard and Reserves will drain nurses away from the civilian health care workforce, certainly to a worthy cause, but this will only add to an existing nursing shortage. There is no time to waste.

Just as there is a need for nurses in extraordinary times, there will always be a need for nurses in ordinary times.

There are now a half-million registered nurses with active licenses who are no longer working in nursing. We may now have an opportunity to bring them back to patient care, or to mentoring or to teaching. I have heard from a number of nurses who have left the profession, who are willing to use their considerable skills and experience to help in this time of crisis. With support for clinical refresher courses and mentoring, it may be possible to bring them back.

But the nursing shortage demands more from all of us. Current events demonstrate the importance of nurses in our health care system. And we know that we need sustained efforts to keep nurses in patient care.

The Secretary of Health and Human Services recently released additional funds to support existing nurse recruitment and education efforts. In addition, both bodies of Congress are actively considering legislation authorizing new nurse education programs.

ANA urges you to support these efforts. We look forward to working with you, the administration, our schools of nursing, and health care facilities to make sure that these nurse recruitment programs are successful.

But even that is not enough. As long as nurses remain disheartened by their work environments and as long as nurses feel compelled to discourage their friends and families from entering this great profession because of the work environment, the root cause of this shortage will remain unaddressed

Mr. Chairman, I have been a registered nurse for 28 years, and 21 of those last years in the State of California. I have been a staff nurse, a nurse executive, and a clinical instructor in nursing. And I know something about nurses. We are called to the profession and, as Melissa said earlier today, by a desire to provide compassionate care to people in need. No one becomes a nurse for the money. We are driven by a desire to provide caring and high-quality health care. We will remain in patient care as long as that is possible. And as long as the unreasonable schedules, the mandatory overtime, our dangerous understaffing and fears of institutional reprisal keep nurses from meeting this calling, many will continue to leave the bedside.

I also believe that it isn't truly a paperwork issue in its entirety or in isolation, since documentation of critical information is so important. But in a workload environment or in a lack of system support, where nurses have to make critical decisions between patient care and fulfilling the documentation requirements, we know that there are added stresses, and it should be looked at in that respect.

Nurses will continue to refuse to be part of any health care system that cannot meet the needs of their patients. My written statement contains specific recommendations on means to improve the environment in which nurses work, and I can't overstate the importance of these workplace initiatives.

We look forward to working with you to make the current health care environment conducive to high-quality care. Improvements in the environment or nursing caseload, combined with the aggressive and innovative recruitment efforts, will help address the nursing shortage. The resulting stable supply of nursing care will support high-quality care for all Americans at all times.

Thank you for this opportunity, and I look forward to answering any questions.

WRITTEN STATEMENT OF MARY FOLEY, RN, MS, PRESIDENT, AMERICAN NURSES ASSOCIATION, WASHINGTON, D.C. – SEE APPENDIX F

Chairman Boehner. Thank you, Ms. Foley.

Ms. Albert, before you begin, your host, Mr. Norwood, has arrived.

Mr. Norwood, I gave your constituent a brief introduction.

Mr. Norwood. Thank you very much, Mr. Chairman. I appreciate you interrupting the testimony to allow me to introduce a friend, Dr. Jean Bartels. Dr. Bartels is currently the Chairwoman of the School of Nursing at my Alma Mater, Georgia Southern University, and remains an authority on nursing practices in education.

Dr. Bartels holds a Ph.D. In nursing from the University of Wisconsin and has received numerous awards and achieved high credentials in over 30 years of distinguished service in the field of nursing. In addition to serving as a professor of nursing, Dr. Bartels is currently the Secretary for the American Association of Colleges of Nursing, where she has been a board member since 1995. She is also on the editorial board for the Journal of Professional Nursing.

Dr. Bartels has conducted research in a variety of nursing practice and higher education areas. Her experience, Mr. Chairman, has focused on community-based nursing practices in education as well as the health care needs of individuals responding to chronic illnesses. Dr. Bartel's current research involves the development and measurement of teaching, learning, and assessment outcomes in nursing education.

She has presented her findings at the American Association of Higher Education and the American Educational Research Association. Furthermore, Mr. Chairman, she has directed workshops, presentations, consultations at the local, State and national, and even international, level related to community-based nursing practices and nursing education.

It is pretty clear, I could go on, but I think my point is clear. Mr. Chairman, we have an expert amongst us, ladies and gentlemen, Dr. Jean Bartels.

Thank you, Mr. Chairman, for allowing me to interrupt.

Chairman Boehner. With that, Ms. Albert, you may begin.

STATEMENT OF SUE ALBERT, RN, MN, MHA, ASSISTANT DEAN OF ALLIED HEALTH, COLLEGE OF THE CANYONS, SANTA CLARITA, CA

I would like to thank the Committee for allowing me to testify. And I would like to thank Mr. McKeon for submitting my name as a witness. It does show his keen insight into the value of the community college associate degree nursing programs.

My focus in this presentation is on the status of nurses, nursing education in the community college, and its ability to decrease the critical nursing shortage that exists in the United States today.

In California, the community college associate degree nursing program provides 70 percent of the registered nursing graduates. Across the Nation, community colleges provide approximately 50 to 60 percent of the registered nursing graduates. The community college nursing programs allow students to progress through the program in as little as 2 years at anywhere from one-half to one-quarter of the cost of students in State baccalaureate programs. For instance, in the California community colleges, the State provides approximately $4,400 per full-time equivalent students as compared to 8,600 for the Cal State University, and 18,600 for the UC system, University of California system. Figures such as these are similar across the Nation.

At the completion of the associate degree nursing program, the graduates generally perform as well or better than students completing the baccalaureate or BSN in nursing. This is demonstrated by their performance on the benchmark for measuring the success of nursing education, the national licensure exam.

Certainly we have talked about the issues with the nursing shortage, and nursing education. We have had a decline in enrollment. California had 469 open positions in schools of nursing in 1999-2000. And when you are ranked 50th in nurse per capita patients, that is a problem.

We have other issues in nursing education. For California, we have very open access policy, which means we cannot screen for admissions into the community college programs. That means that our attrition rates are increasing. If you bring a person into the program and they drop out of the program, that is an empty position and fewer persons are graduated.

We have a shortage of nursing instructors. In California alone, we will have 150 open positions in 5 years. And as with any school across the Nation, we need classrooms, we need clinical lab space, and we need clinical space.

Increasing access for education, we need economic support for students. I am not talking scholarships. I am talking living expenses. When you are looking at the person going into nursing today, those people are the ones that are single parents. They are raising children. Just simply paying for tuition isn't going to help them. We need work-study programs in which students work in a hospital and get paid while they are working.

This allows them to learn nursing and still be able to support a family.

We certainly, as I said before, need more classroom space, more skills lab space, and more clinical practice space. We have to better utilize the space that we have. We need technology for the skills lab. Health care technology changes approximately every 3 years. That means skills labs must be updated every 3 years. Funding is needed for all of these. We are looking in our own district at using bonds.

Web sites for better use of clinical sites need to be expanded. This allows for better utilization by all the schools using the hospitals. When four or five schools are using a hospital, that impacts quite a bit on their nursing staff. And the staff nurses also need to be reimbursed for their roles as preceptors with students.

Alternative modes of instructions need to be provided to allow for the diverse learning needs of the population. Special provisions need to be made for persons for whom English is not their first language. We need more instructors. We need to have the education from ADN up through Ph.D. Subsidized.

Partnership between industry and education needs to be reported. At College of the Canyons, we have a new division. We have my new position, and my position is to expand the program. They have opened a second nursing allied health skills lab, using grant money and industry support.

We have a general obligation bond for 82.1 million to provide additional classroom and lab space. We are looking for industry support for faculty positions. We have created articulation with high schools so that students can take anatomy and physiology and bring it right into our program. We have articulation with Cal State University-Northridge to move them to the baccalaureate degree faster.

We have a gender equity tutor. We have a male student who is there to tutor our students and help them through and provide a role model for males.

We just developed a course for medical terminology for English as a second language. We have 119 students on our waiting list after opening up application, but we have no place to put them.

It is imperative that nursing improves its image. It is the responsibility for all nurses and mass media. We need funds for growth as we look at how to get the nurses. And the government must recognize the need for total quality management, quality products that are created faster, cheaper and better. Associate degree nursing programs do this. Associate degree nursing programs represent a successful avenue to an affordable and high-quality education for many individuals who would not otherwise be able to pursue the career of nursing.

These programs are the most cost effective to the taxpayers. These programs increasingly reflect the diverse demographic composition of the Nation, and the graduates have reliably and consistently demonstrated competence and excellence in the workplace.

At this time we are looking at the very real possibility of further terrorist attacks and wars. We have no concept of the number of casualties that we will incur in this process. We are already in a nursing crisis. We need nurses and we need them now, not in 4 years. It is an absolute necessity that all nurses and all levels of government work together for solutions to the nursing crisis.

WRITTEN STATEMENT OF SUE ALBERT, RN, MN, MHA, ASSISTANT DEAN OF ALLIED HEALTH, COLLEGE OF THE CANYONS, SANTA CLARITA, CA – SEE APPENDIX G

Chairman Boehner. Thank you, Ms. Albert.

Ms. McCullough, you may begin.

STATEMENT OF CAROLYN McCULLOUGH, MA, RN, NATIONAL COORDINATOR, NURSE ALLIANCE, SERVICE EMPLOYEES INTERNATIONAL UNION, WASHINGTON, D.C.

Thank you for allowing me to testify at this hearing on behalf of the 1.4 million members of the Service Employees International Union, of whom 110,000 are nurses. My name is Carolyn McCullough. I am a registered nurse and the national coordinator of SEIU's Nurse Alliance.

This hearing was changed because of the devastating attacks on September 11th. Because of these tragic events, thousands of people needed medical care, and nurses were on the front lines delivering this care. Nurses were ready to provide whatever care was needed, without being asked, and without concern about time or hours worked and about being paid. But this crisis highlights the need to have adequate numbers of nurses. Therefore, addressing the current nursing crisis and the impending shortage is imperative.

In May 2001, our Nurse Alliance released "The Shortage of Care," a report that is helping to redefine the Nation's nursing shortage. The report claims that the real problem is a shortage of nurses willing to work in hospitals under current conditions.

This opinion was also shared by the GAO in their recent report, "Nursing workforce: Emerging Nurse Shortages Due to Multiple Factors." We view the situation as a staffing crisis rather than a nursing shortage. Systemic understaffing by the industry has led to unbearable working conditions and increasing concern about the quality of patient care.

Inadequate staffing has led to increased numbers of medical errors. In 1999, the Institute of Medicine found that between 44,000 and 98,000 Americans die each year due to medical errors. More people die of medical errors than from motor vehicle accidents, breast cancer, or AIDS. A majority of nurses in our SEIU survey identified understaffing as the cause of medical errors, and the situation, they say, is not improving.

A devastating side effect of the understaffing crisis is that of abuse of mandatory overtime. Nurses are often mandated to work back-to-back 8-hour shifts or 4 extra hours on top of 12-hour shifts. This threatens patient safety. An exhausted, overworked nurse is not as alert and accurate as a well-rested one.

According to our survey, nurses in hospitals work an additional 8-1/2 weeks of overtime, on average, every year. Nurses are stretched to the limit. They are experiencing high levels of stress, chronic fatigue, and work-related injuries. These conditions are driving nurses from hospitals.

The current supply of nurses far exceeds the demand. According to a recent Health Resource Services Administration report, there are approximately 500,000 nurses who have licenses but are not practicing.

RNs employed in hospitals have decreased from 68 percent in 1988 to 59 percent in 2000. Few young people are entering nursing. Nursing school enrollment has declined in each of the last 6 years. A Washington State nurse gave these reasons why she is leaving hospital nursing, and I quote:

"it is difficult to tell you how terrible it is to work scared all of the time. A mistake that I might make could easily cost someone their life and ruin mine. Every night we routinely race the clock. All of us do without lunch and breaks, and work overtime, often without pay, to ensure care for our patients. We have patient assignments 2-1/2 times greater than the staffing guidelines established by the hospital.

"I cannot continue to participate in this unsafe and irresponsible practice, so I am leaving; not because I don't love nursing, but because hospitals are not safe places, not for patients and not for nurses."

Nurses who are in unions have turned to the bargaining table to change their working conditions in order to ensure safer staffing and better patient care. At present, collective bargaining is the only venue that nurses can use to protect themselves against unfair and abusive working conditions such as mandatory overtime that jeopardize quality patient care.

SEIU's nurses have negotiated limits on mandatory overtime and staffing standards. Yet our right to collectively bargain is constantly under threat. Two recent Supreme Court decisions have eroded nurses' rights to act collectively. As these challenges to nurses' ability to address workplace and quality patient care issues through collective bargaining mount, it becomes more imperative that policymakers act now to ensure decent working conditions for our country's nurses and ensure safe patient care and an adequate nurse workforce for the future.

SEIU and other unions have introduced legislation on the State level to establish staffing standards, ban mandatory overtime, and provide whistleblower protection. California was the first State to pass legislation to require staff-to-patient ratios in hospitals. In an action of historic proportions, Kaiser-Permanente has recently become the first employer to endorse the ratio proposal put forth by the SEIU California Nurse Alliance. Maine and Oregon have passed legislation banning mandatory overtime.

On the Federal level, legislation has been introduced to attract new people into the nursing profession by making it easier to access educational and training resources. We applaud these efforts; however, this will not address the fundamental problem. These measures will only treat the symptoms, not cure the disease. The solution to the nursing crisis lies in the establishment of safe staffing standards in our hospitals.

We must set staffing standards linked to the acuity of patients, skill of the staff, and skill mix. We must make staffing a requirement for all hospitals receiving Federal taxpayer dollars.

The Federal Government must provide adequate oversight of our hospitals and reform the industry's self-monitoring system under the Joint Commission on Accreditation of Healthcare Organizations. And we must protect nurses who blow the whistle on staffing problems that jeopardize the quality of care.

On the educational front, SEIU would encourage this committee to explore the establishment of public-private partnerships for educational programs that establish career ladders for nursing assistants to become licensed practical nurses, and for licensed practical nurses to become registered nurses. Tens of thousands of dedicated workers in our country's hospitals, nursing homes, and in-home care, are a valuable resource that we can use to address our future shortage needs.

SEIU is currently working on developing such a program jointly with a number of employers. This program will incorporate tuition reimbursement, the use of online distance learning, a clinical component based in the workplace, and a learning assessment tool that credits the student for prior learning and experience. The providers will be reputable institutions of higher education.

These types of programs should be supported nationally, and we would be happy to assist the committee in any way possible. But there is a step we can take today, immediately, to stop the hemorrhaging; and that is to put a ban on mandatory overtime. SEIU and other unions are working with Representative Stark to introduce legislation that would ban mandatory overtime.

Thirty years ago, I became a nurse because I wanted to make a difference. Caring for people when they are ill and at their must vulnerable, especially those so often underserved, really appealed to me. I thought I could help them get better and stay healthy. And what I found out is that I really could. I have spent many years as a nurse, and along the way I learned that nurses are the critical link between people and health care, and without nurses there is no health care.

I look forward to working with you and will be happy to answer any questions.

WRITTEN STATEMENT OF CAROLYN McCULLOUGH, MA, RN, NATIONAL COORDINATOR, NURSE ALLIANCE, SERVICE EMPLOYEES INTERNATIONAL UNION, WASHINGTON, D.C. – SEE APPENDIX H

Chairman Boehner. Thank you, Ms. McCullough.

Dr. Bartels, you may begin.

Ms. Bartels. Good afternoon, Mr. Chairman.

Chairman Boehner. Dr. Bartels, if you could suspend for just a moment. We do have a vote on the House floor. Several of our Members have gone to vote. Maybe they will return quick enough for us to go vote, and we can continue the hearing. Otherwise, we will have a short pause, just so you know what the confusion up here is. You may begin.

STATEMENT OF DR. JEAN BARTELS, CHAIR, SCHOOL OF NURSING, GEORGIA SOUTHERN UNIVERSITY, STATESBORO, GA

Good afternoon, Mr. Chairman, and Members of the Committee. Thank you for inviting me to speak to you today about educating the future workforce of nurses. I am Dr. Jean Bartels, the Chair and Professor of the School of Nursing at Georgia Southern University in, proud to say, rural Statesboro, Georgia.

I am also here presenting the views of the American Association of Colleges of Nursing, which represents 556 baccalaureate and graduate schools of nursing across the United States.

I am heartened that the Congress is investigating the nationwide shortage of nurses available to care for all of our citizens. And I am hopeful that Congress will investigate the health care education infrastructure, part of which is the current unprecedented number of nurses we have working, 2.7 million who make up the backbone of today's workforce, and in memory of those hundreds of thousands of nurses who have always been on the front lines every time this country has been in conflict and will be there again this time.

The United States is in the midst of a nursing shortage that is projected to intensify as baby boomers age and the need for health care grows and becomes even more complex. Compounding the problem is the fact that the pipeline of new nurses is shrinking. Additionally, faculty shortages are reducing the capacity of the educational system to increase enrollment to offset current and future shortages. Faculty shortages at schools of nursing across the country are contributing to the overall decline in new enrollments. AACN data shows that baccalaureate nursing schools have turned away about 4,967 qualified students across the United States due largely to insufficient numbers of faculty, clinical sites, classroom space, clinical preceptors and, again, budget constraints.

More than a third of the schools surveyed pointed to a faculty shortage, particularly for faculty prepared at the doctoral level, as reasons for not accepting all qualified applicants into entry-level baccalaureate programs.

As enrollments continue to plunge, States and local communities are developing very innovative approaches to attracting students to the nursing profession, and funding their education through scholarships and loan forgiveness programs.

In past cyclical nursing shortages, Congress has acted decisively by funding new initiatives that increase capacity in nursing schools and attract new students to the profession. Again, we urge Congress to take this shared burden with the States and private sector.

Without question, new initiatives are needed in the areas of faculty preparation, enrollment incentives and post-baccalaureate residency programs to safeguard our Nation's health care delivery system. At Georgia Southern University, initiatives in these areas have actually proven to be fairly successful, and I would like to share with you several innovative ideas and success stories from Georgia Southern.

The first thing that we discovered was creating fast-track nursing scholarship programs and loan programs has provided an opportunity for many of our nursing faculty to go back to school supported by local and Federal grants. Providing scholarships and loans to students to become nurses is really absolutely ineffective if you have inadequate faculty to educate them. It is the old adage of when you are out of faculty, you are out of mission. When you are out of mission, you are out of nurses in this case.

To increase the number of nurse educators, the Fast-Track Nursing Faculty Shortage Scholarship and Loan Program could provide economic incentives to both masters and doctoral students who commit to serving as faculty members. This program should require participating students to serve as educators in schools of nursing for a number of years equivalent to the time that that participant has received Federal support. At Georgia Southern University, as I mentioned, local and State grant support has facilitated our ability to hire additional educators and several eminent scholars who are focused on meeting the needs of our rural, very underserved communities.

Second, we should establish a capitation grant program. Schools of nursing must have strong infrastructures equipped with high-tech communications equipment, teaching software and labs that simulate hospital-patient care units. A capitation program similar to the one that was created in the 1970s could help to recruit new students and help us to retain faculty. With Federal support of $1,200 for each full-time student enrolled in the collegiate nursing program, schools could purchase equipment, hire faculty and build new learning labs.

As a model, Georgia Southern University, funded by State and local initiatives, will soon open a new nursing building featuring research and nursing skill labs, distance learning classrooms and a community nursing outreach clinic serving the underserved needs of our local community. The facility will enable the school to attract increased numbers of students and qualified faculty to the region by using technologically sophisticated clinical labs, Web-based learning technologies and distance learning initiatives, which I will point out my faculty are ready, are highly skilled at providing to those who can't reach educational environments so that we can educate all the future generations of professional nurses.

And third, creating a post-baccalaureate nursing residency program would ensure the successful transition of new nurses from student to expert nurse and assure that our Nation's health care system includes highly educated nurses with clinical expertise. For example, Georgia Southern's faculty partnership with the local rural hospital, East Georgia Regional Medical Center, has resulted in the development of a program to train nurses as mentors to both students and new graduates. Faculty worked with the hospital to achieve Magnet status by increasing their involvement in committees and study groups that were designed to help that institution look at working conditions for their nurses.

Plans are under way to reestablish a nurse extern program for new baccalaureate graduates and to develop joint leadership training initiatives for both practicing nurses and undergraduate students. I am happy to report that that process has resulted in our rural environment's retaining 80 percent of the nurses we educate in rural underserved areas, 14 percent of which are men and 28 percent of which are women and men of ethnic minority backgrounds.

Once again, another cycle of nursing shortages is wreaking havoc in the health care delivery system. As the Congress investigates solutions to the current shortage, it must focus on the long-range problems that affect nursing as a profession. Steps really need to be taken to evaluate and improve the practice environment, and simultaneously schools of nursing must be adequately funded to strengthen and expand the capacity to educate the nursing work force for the coming century. The nursing profession must create a career pathway that both attracts individuals to nursing and supports current practitioners in their chosen career.

In closing let me offer a word of caution, however. During shortages of nurses, there has been a trend to push nurses through abbreviated academic programs. Lowering educational standards is an inappropriate and potentially dangerous response to a shortage of health care professionals, and the short-term responses will interfere with the delivery of quality patient care. As an intensive care unit nurse with many years of experience, and as mother of a daughter who needed the health care system recovering from a malignant brain tumor, I personally expect only the most highly educated, well-prepared nurses to be at the bedside both as my colleagues and as the providers of care for my family. I think we can really demand no less for all citizens of this country.

Thank you, and I look forward to answering your questions.

WRITTEN STATEMENT OF DR. JEAN BARTELS, CHAIR, SCHOOL OF NURSING, GEORGIA SOUTHERN UNIVERSITY, STATESBORO, GA – SEE APPENDIX I

Chairman Boehner. Dr. Bartels, thank you for your testimony.

We are going to take a short break, and Mr. McKeon will resume the hearing as soon as he gets here, and then I will be back.

Mr. McKeon. [Presiding.] Tag team match we have going here.

Dr. Garner?

STATEMENT OF CATHERINE GARNER, DrPH, RN, FAAN, DEAN, COLLEGE OF NURSING AND HEALTH SCIENCES, UNIVERSITY OF PHOENIX, PHOENIX, AZ

Thank you, Mr. McKeon and Members of the Committee. We appreciate the opportunity to be here today. The University of Phoenix is the Nation's largest private institution of higher learning with 120,000 students, including 6,000 who were called to active duty within this last week. Over 26,000 of our students go to school completely online.

The College of Nursing is 10 years old, and in those 10 years, we have grown to over 2,000 undergraduate students and over 1,800 graduate students looking for their master's degree in nursing, including some family nurse practitioner students. We are at 37 percent minority currently and over 10 percent male and see that as a great success, albeit that our average age of student is 37.

We are geared primarily to the working adult, and we attribute some of our success to an innovative teaching learning model that is designed exclusively for the working adult, to our just-in-time curriculum and our use of expert practitioner faculty. We offer one course at a time on-ground that allows the student to work full time and also pursue their education. The classes are kept small with a 1 to 10 ratio for online for faculty and students and a 1 to 15 ratio for our on-ground classes.

Our over 300 plus practitioner faculty work full time in their profession while teaching part time, and all are prepared in their area of expertise. We have absolutely no trouble at recruiting academically prepared faculty at the moment despite the fact that we have no career track or a tenure system. Our faculty includes chief nursing executives, State board of nursing staff and members, managed care professionals and chief financial officers.

Our nursing education establishment must embrace the concept of public-private partnerships particularly to deal with the increasing need of health professionals to have greater skills and advanced critical thinking. The traditional year 4-year BSN students are rapidly losing ground, and we are looking again to some of the traditional roots of nursing, vocational development in high schools, our strong community college system with associate degree nursing programs that articulate onto the bachelor's degree and master's degree in nursing programs. These programs need to allow people to work full time to support their families while going to school for advanced education.

In fact, what we are seeing is that many men and women do, in fact, want a career in nursing, and that there are 2- to 3-year waiting lists at the community college level. A majority of those on waiting lists are actually the ethnically diverse, nontraditional students who must also work to support their families. The traditional semester daytime class model is not designed to support these students. We need to work actively to develop innovative delivery models and to encourage the innovators in our nursing education systems.

In a number of communities we are partnering with the community college system and a number of local hospital employers to double the number of 1-year community college licensed practical nursing graduates and then to articulate them seamlessly into our 30-month LPN to BSN program. This allows the student to work full time, support their family and complete their nursing education in a relatively short period of time. We are going to offer this program to over 900,000 licensed practical nurses over this next year, and we are hoping to encourage them to move into the registered nurse program. The program also accommodates the active duty medic corps and allows them while on active duty to achieve their bachelor of science and nursing over a 30-month period of time. That is helping us with our 2005 goal of an all BSN corps by 2005.

Our distance education model gives us educational opportunities in rural areas as well as for those nursing students who work odd shifts to pursue education at their convenience. The online cohorts bond greatly, and in December our first national cohort of the Nation's 38 Children's Hospitals will have a pediatric group starting their master's degree online.

We hope the committee will consider some of the following things that we would like to recommend. The tuition loan forgiveness is vitally important to encouraging people back to school and having them complete education. This committee oversees the largest student loan program in the Nation that serves millions of students each year. We are asking you to consider expanding the loan forgiveness to nurses to your existing student loan program for teachers, and it would be an efficient way of promoting recruitment and retention efforts.

We would like to encourage members of this committee also to work with the Department of Education and to change laws and regulations that are creating roadblocks to expanding educational opportunities to these nontraditional students, particularly in the online distance modality, and also to encourage employers to see education of their current work force as a way to recruit and retain people in our profession.

Thank you again for this opportunity, and I look forward to answering any questions you might have.

WRITTEN STATEMENT OF CATHERINE GARNER, DrPH, RN, FAAN, DEAN, COLLEGE OF NURSING AND HEALTH SCIENCES, UNIVERSITY OF PHOENIX, PHOENIX, AZ – SEE APPENDIX J

Mr. McKeon. Thank you very much.

Mr. Lynn?

STATEMENT OF GEORGE F. LYNN, PRESIDENT AND CEO, ATLANTICARE HEALTH SYSTEM, TESTIFYING ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, D.C.

Thank you, Mr. Chairman, Members of the Committee. I am George Lynn, president and CEO of AtlanticCare, southeastern New Jersey's largest health care delivery system, and I am here today as a member of the American Hospital Association's board of trustees representing AHA's nearly 5,000 hospitals, health system and health care provider members. Thank you for the opportunity to address an issue of concern to all, the immediate and long-term shortage of nurses.

AtlantiCare's integrated network of services encompasses Atlantic City Medical Center, a 581-bed, two-divisional regional health care institution. Our system of more than 2,800 health care workers includes 800 registered nurses and 350 physicians representing the full spectrum of medical care.

Mr. Chairman, before I begin, I would like to state on behalf of the entire hospital community how proud we are of how our colleagues in New York, New Jersey and the Washington area and other parts of the country responded to the terrorist attacks of September 11. Physicians, nurses, emergency personnel and all members of the health care work force provided care and relief to those in need. And we are fortunate as a Nation to have such individuals who have dedicated their lives to the health care field.

Mr. Chairman, you are familiar with the problems of the work force shortage. The demand for hospital care is rising. Demand is also increasing as we care for baby boomers, as we have heard, who are already being treated for cancer, heart disease and orthopedic conditions. The supply of nurses is not keeping pace with demand. Overall enrollment in nursing schools has decreased 22 percent since 1993, resulting in a dearth of nurses to replace retirees.

The bottom line is that the demand for health care may soon exceed our capacity to provide it, and that was our analysis before the world changed on September 11. My health care system and the nurses and doctors who worked there were on alert waiting and then praying for care for the New York survivors. But the tragedy and the death toll were unimaginable. For our Nation, the result of those tragic events is a heightened state of disaster readiness. For our Nation's hospitals, it means disaster preparedness plans must be revised and upgraded.

Plans and resources essential to a prepared Nation will be critical. Even stronger relationships among community firefighters, police, health care workers and other emergency response team members will be critical. And hospitals' continued leadership, as an integral part of this Nation's essential community infrastructure will be critical. The events of September 11 that raise new questions about readiness for any number of contingencies and sufficient numbers of hospital personnel, especially nurses, will be essential to ensuring America's readiness.

So how can we address these shortages? Like many health care facilities, AtlanticCare is constantly looking for ways to develop innovative working environments and to promote nursing as a career. Our programs include providing flexible hours, enhanced compensation and benefits, on-site childcare and programs to attract youth to health care areas. We sponsor RNs to BSN programs, nursing scholarships, a workplace improvement task force made up of hospital staff, and partnerships with local schools and community organizations to promote health careers.

Our approaches are proactive and creative, and they are working. We have a lower-than-average nursing vacancy rate. But as good as they are, they are not enough. Finding long-term solutions will take a collaborative approach from all stakeholders, including high schools, academia, professional organizations and our local, State and Federal Governments.

The AHA has endorsed several bills aimed at expanding the supply of nurses, including H.R. 1436, the Nurse Reinvestment Act, sponsored by Representatives Sue Kelly and Lois Capps. As Representatives Kelly and McCarthy have presented today, this bill addresses educational incentives for nursing students, including the creation of a national nurse service corps. While the Nurse Reinvestment Act would assist in the education of future nurses, the American Hospital Preservation Act, H.R. 1556, would give hospitals a fully inflationary update so they can provide fair and reasonable wages and benefits. And the Area Wage and Base Payment Improvement Act, H.R. 1609, creates a floor on the Medicare wage index to better balance work force competition in rural and urban areas.

The AHA is also taking steps to alleviate the shortage of caregivers. In order to address this, the AHA convened in April a commission on work force for hospitals and health systems. This diverse group of stakeholders includes hospital administrators, nurses, academics, business and organized labor leaders. The final report, which will include recommendations for solutions to this national dilemma, will be presented at the AHA annual meeting next spring.

Mr. Chairman, the Nation faces a critical shortage of nurses and other health care workers. To turn things around, every stakeholder must work together to respond to this growing problem that will personally affect each of us in the coming years, and in order to properly care for our patients now and in the future, we encourage you to support these initiatives to expand the nursing work force and meet the growing health care needs and readiness demands of our Nation. Thank you.

WRITTEN STATEMENT OF GEORGE F. LYNN, PRESIDENT AND CEO, ATLANTICARE, TESTIFYING ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, D.C. – SEE APPENDIX K

Mr. McKeon. Thank you very much.

As I mentioned earlier, I really wanted to thank the Chairman for holding this hearing. I was aware that we had a serious problem, but I am much more aware today after having listened to the testimony. I am also encouraged, because I hear all of the good things that you are doing to address the problem. And I think that while much is needed to be done, there are very good people out there doing very good things. So I feel good about that.

Dr. Garner, I spoke at one of your graduations a few years ago, and there were many graduates in nursing. You mention in your testimony about innovative delivery programs. I don't know if you're aware of Mr. Isakson's bill, and he probably wanted to talk a little bit about that, but I wanted to give him a plug, too. His bill, H.R. 1992, does address some of these issues and makes it easier for schools to be creative and to do some different things in reaching out to people to get more people into the program. And I think it would be very important for this particular problem of nursing shortages to get his bill passed, and he is to be commended for the work he has done on that.

Tuition loan forgiveness, I think that is also something we can look at, and I am sure we will as we go through this process.

Mr. Lynn, you mentioned throughout your testimony the efforts that hospitals are undertaking to recruit and retain nurses. Would you please expand upon these efforts? I served as a member of a board and chaired a board at a local community hospital. This was 15 years ago, and the problem was serious then, and I am concerned that it is even worse now. Would you please expand upon those efforts?

Mr. Lynn. We have taken our message into the high schools to try and make students aware of the variety of health care careers that are available to them. We don't think that in our community we have done as good a job as we should have in reaching out to students in high school. We have also partnered with our community college and with Richard Stockton College and Thomas Jefferson University to provide opportunities for education. We have sponsored scholarship programs for our employees and for dependents of our employees, which have been very successful. We have sponsored a series of scholarship efforts with the Hispanic Alliance of Atlantic City and with the NAACP where they select applicants for our scholarships, and we provide mentors and tuition and extern programs during their education. So it is a fairly far-reaching, community wide effort on our part to raise the level of awareness of not just nursing careers that are available, but also the spectrum of health care career opportunities.

Mr. McKeon. I heard Ms. Velazquez state very clearly that money was not the most important thing, that working conditions were very important, and that sounds like something the hospital association could really work towards addressing. Do you have efforts that you are making in that regard?

Mr. Lynn. We are working on working conditions every day. In January we took 17 care providers and support personnel offline for 30 days in our organization and asked them to redesign the health care delivery system as we knew it and to work the edges of innovation to try and find ways that we can solve the problems that have been talked about today, such as the burden of paperwork, not having enough time to spend with the patient, how to use additional personnel to support the activities of nurses.

If I could, I would like to address the issue of compensation. In all of the surveys that we see, I don't think I can ever remember one where compensation was the first and most important issue, and I think you have heard today that nurses didn't get into nursing to get rich. But compensation figures into every one of those surveys that I have seen, and I think everybody in this room who works within direct patient care and health care knows that there is a number, a salary and compensation number at which point the 500,000 people who have licenses but don't practice direct patient care begin to return to hospitals, and high school seniors who have choices begin to elect nursing. We have to find that number.

My institution and most hospitals I know peg our nursing salaries at a market rate, but I think we all know that that market rate doesn't reflect the compensation that should take place for the kind of responsibility and authority that you heard the first panel talk about. So that is a battle, I think, that we all have to share, and it is to find the right compensation package. That creates the platform that I think we need to recruit and retain nurses. All of the other activities that we engage in are to improve the quality of work life.

Mr. McKeon. I don't see anybody that knows what that means. Maybe it meant my time is up. Mr. Scott?

Mr. Scott. Thank you, Mr. Chairman.

Let me follow up on that, Mr. Lynn. You indicated it was the market rate. When people leave nursing, what kind of jobs do they take instead?

Mr. Lynn. Nurses are in demand by industry for employee health programs, for school systems. HMOs are now offering opportunities to nurses in private physician office practice. There are a lot of opportunities available for nurses that weren't there 10 or 15 years ago.

Mr. Scott. Do those positions pay more than hospitals?

Mr. Lynn. Generally speaking, they don't pay more. They have other benefits that nurses find attractive, such as a policy of working an 8-hour day with weekends off, and they are willing to sacrifice something in the way of compensation and benefits in order to get that lifestyle.

Mr. Scott. Ms. McCullough, you indicated there was a difference between staffing and shortages. What did you mean by that?

Ms. McCullough. There are more than enough nurses than are needed right now to meet the demand within the country. This shortage that we are looking at is coming, as we had said before in the first panel, when the baby boomers are reaching 60 and 65, and that is in 2020. We need to get those 500,000 nurses back to the hospitals, and the reason they have left is because, as I have said, the working conditions are deplorable.

As Mr. Lynn has said, they leave for places where they can have a more reasonable, normal work life. And the other thing is what we heard from the two nurses on the first panel regarding the inability to deliver quality care daily to their patients. This is a real burden and a real drain on the nurses' willingness to continue to work in that environment.

The story that I told from the Washington State nurse is quintessential as an example of what nurses are facing when they say things like hospitals are not safe for patients anymore, and they are not safe for nurses.

Mr. Scott. I yield to the gentleman from Ohio.

Mr. Kucinich. I thank the gentleman, and I thank the Chair for calling this hearing. I wanted to ask for unanimous consent to submit a report relating to the mergers, drug costs and health caregivers staffing ratios along with some points that illustrate the study, and together with a question that I pose.

Could I have unanimous consent to submit this material for the record?

Mr. McKeon. Without objection, so ordered.

Mr. Scott. Thank you. Reclaiming my time.

Can you explain the problem with paperwork, Ms. Foley?

Ms. Foley. I don't want to underplay the fact that there are concerns being raised right now and, in fact, a lot of attention being placed on paperwork, but I don't want it to be taken out of the context in which it really should be.

If you ask a nurse on a survey of what concerns them, paperwork will not appear on the top of that list. It is the sense of satisfaction that is primary to their care and to the souls of nurses in these days. I think Melissa spoke well about an environment where her priority for 12 hours is on the patient and obviously the family. She told the beautiful story about the husband and the wife she was caring for in terms of both physical and mental health at that time. And she very honestly acknowledged that because of her commitment to that care, she would save some of that documentation that could be saved until the end of the shift, which often may have run overtime.

The reality is our systems are not as efficient as they should be. If Melissa is in the room and charting at the critical care unit bedside, if we had some good automation, then perhaps much of that documentation would be entered automatically in a medical record, and there wouldn't need to be separate steps taken numerous times to do the same work. That work would have been critical and important to that patient's welfare; his vital signs, his stability on the monitoring machines.

So it is not to underplay the fact that, yes, it is a factor, but I would not say that if we stopped charting, that nurses would necessarily be any happier. In fact, the care would be undermined, and the sense of satisfaction really has to be looked at. What are the arrangements in that work life that give support to the nurse being able to give the time and the attention to that patient and to their family? Are there enough hours? Is their patient assignment appropriate for their ability to give that attention?

I would shudder to think of that pediatric unit with two registered nurses and 16 unwell children and the stress they must feel that at any time 14 children are not being looked at by a registered nurse. It has to be brought back into context in terms of the workload, and much of the documentation is absolutely essential. And I am not here to argue that there isn't some duplication that could be improved upon by some system improvements.

I also want to jump in, if I could, about improvements that are being made across this country in the actual care environment. Lisa from Fairfax Hospital is a nurse at a hospital with the very first Magnet status in this country. They are a Magnet hospital, and that is an award that has been given to only 37 hospitals in this country, but there are hundreds of hospitals and long-term care centers looking at the opportunity to make improvements so that they, too, could be recognized with a Magnet credential.

Now, it isn't whether we give that credential out, it is what the environment can be improved to look like and the concept of what are the forces of magnetism. The support by the university is a wonderful example of an academic setting helping an institution of care. The examples given, nurse participation in governance, whether it be through shared governance or through collective bargaining, is an absolutely root cause of improved nurse satisfaction and better decision making if nurses who give the care actually participate in the decision making in the allocation of the care.

Some of those key critical decisions, whether we are building up the work force or reducing the work force, should come from the perspective of how does the care get given and how can it still be maintained at a high quality level. Opportunities to look at your own schedule, a very important concept of participating in the decision making; the measurement of patient care outcomes, the ability to take a look at a unit and see how that care is impacted by a change in staff and a change in the computer system, very important for us to know more about that care.

Magnet hospitals incorporate all of those concepts, and I think they offer a set of solutions to the dilemma of how to make our environment better. These settings have lower turnover, higher retention, higher patient satisfaction, higher nurse satisfaction, and even have lower needle stick injuries. So we have a growing body of research that tells us we have some answers to the questions of how to make those improvements. Thank you.

Mr. Scott. I yield back the balance of my time.

Mr. McKeon. Mr. Isakson?

Mr. Isakson. Thank you, Mr. Chairman.

I would like to add my praise to that of Dr. Norwood for Dr. Bartels being here today from Georgia Southern University, School of Nursing. And let me ask you, of your students, what percentage of them are typical college-age students studying for their first career, and what percentage of them are adults that are returning to a college campus to learn?

Dr. Bartels. There are about 95 percent traditional-age students. Almost every single one of them wants to go into the high-risk, low-served areas in terms of critical care, emergency rooms. They are the very young people that we need to get in at the ground level where we have got the biggest shortages. Five percent are perhaps somewhat nontraditional, but yet they are still under 30 years of age, and about 14 percent of them are males. And we have between 28 and 30 percent of students with minority backgrounds.

Mr. Isakson. Ms. Garner, you have 2,000 students in undergraduate nursing, 1,800 in graduate nursing, and the average age is 37. I presume, then, most of your students are second career. Is that a fair assumption?

Ms. Garner. Actually in our undergraduate program we have concentrated in the past on the RN to BSN, so that 1,800 does represent working registered nurses who are pursuing the bachelor's degree, majority of whom are looking at supervisory positions or moving into a teaching ladder.

Mr. Isakson. What about the 2,000 undergraduates?

Ms. Garner. Our undergraduates are all working adults who are at the RN level already, and we are just now in this next year expanding to the LPN level.

Mr. Isakson. Are your 36 campuses that these courses are offered on, on the distance-learning model? Are they all campuses of Phoenix, or are they campuses of other institutions that are doing a joint venture with Phoenix?

Ms. Garner. Currently, they are campuses of Phoenix, although I hate to term it "campus" because we don't own any real estate. We lease space, and that allows us to expand and contract easily. And all of our student services are offered online. So our enrollment, and our academic advisement are online. Three thousand of our students go full time on-ground, and 1,000 of our students go full time online.

Mr. Isakson. I wanted to also appreciate Mr. McKeon's acknowledgment of the distance-learning bill, 1992, and appreciate your testimony acknowledging that in it as well. And I think Phoenix has proven to be an excellent example in terms of distance learning and second careers in many, many fields, so I want to thank you for what you are doing.

I have one last question, Ms. McCullough. When you say hospitals aren't safe for patients and nurses, that is a relative statement, isn't it?

Ms. McCullough. I was quoting the story of the nurse from Washington State.

Mr. Isakson. My experience, just for the record, is a lot of times people read things that are said here, and the next thing you know, it is a headline somewhere.

Mr. Lynn, would you agree that most hospitals are safe, but we can always do better?

Mr. Lynn. I would agree most hospitals are safe, and hospitals are committed to continuous quality improvement. That is a daily effort in hospitals all across this country.

Mr. Isakson. I yield back my time, Mr. Chairman.

Mr. McKeon. Mr. Tierney?

Mr. Tierney. Thank you, Mr. Chairman, and thanks to the members of the panel.

Ms. Foley, if I could ask you, I know members of my staff and you had conversations on what I thought was an interesting topic about whether or not there was anything Congress could simultaneously do about this situation in nursing and the problem we have now with layoffs in the airline industry. Would you talk about that conversation that you had and your ideas?

Ms. Foley. I have been brainstorming, being a frequent flyer and being struck by how massive the potential layoffs are in that industry, an industry where there is great ethnic diversity in the people who have chosen the customer service field. I thought what a wonderful opportunity. We need more customer service-oriented, ethnically diverse, committed Americans to become nurses. Perhaps there is an opportunity here to do a partnership, a take-off on work-to-work from one field to another and have a ready response to a particular need.

It was just a brainstorm I have been having, and I just think there are opportunities for us to capture the excitement of nursing for people that may not have thought about it before. In my written testimony I mention that a couple of the folks who watched the nurses respond at the World Trade Center, have already asked for information about how to become a nurse. So I think there is awareness, and perhaps this could be a relief program that Congress could look at.

Mr. Tierney. Some of the background that flight attendants have corresponds to things that nurses need.

Ms. Foley. In fact, the original flight attendants were nurses. The very first requirements were that they be nurses. I was at the Red Cross headquarters the day after this event, and an American Airlines flight attendant had just become a nurse. She wasn't sure she wanted to fly, but she sure knew she wanted to be a nurse that day. And she was struggling with her own career choices, but I thought it was interesting she made that transition.

Mr. Tierney. This question is basically for anybody who feels they want to contribute to the answer. How long do you think the transition time would be in terms of providing flight attendants with the necessary tools or educational background that they need to get them to the point where they are in service?

Ms. Bartels. I think the time could potentially be accelerated. We have accelerated programs to get people who have various kinds of credentials up to speed a little bit quicker and into the work force quicker; for example, medics and EMTs and people who also have similar kinds of backgrounds.

I would caution that while it is possible to actually think about how to do that, the reality is there are not enough resources in terms of faculty, clinical placement sites and many other things that are needed. Having a big pool is a great idea, but if you look at the legislation that was passed in Texas recently, you will see that there was some legislation that really gave resources to bring more people in. Immediate response of 3,000 people who were calling schools wanting entry into those programs had to be turned away, 3,000 of them, because there was not enough space to put them. So while the pool may be big, the resources to educate that pool are very limited.

Mr. Tierney. Ms. McCullough, if we had that program and added these people to the rest of the pool, I fear that it wouldn't have done anything about retaining them or improving their conditions to make them want to stay in their profession. If we increased the size of the pool by somehow encouraging people to go from one career to another, we still are confronted with a situation of how do you retain them.

Ms. McCullough. We don't want to create a revolving door. If we don't adjust the working conditions, we can spend a lot of money in all sorts of innovative ways in bringing people into the profession. However, if the workplace is not conducive for them to do the kind of nursing they want to do, for them to feel that they have actually helped patients and for them to have some semblance of a life, they are not going to stay. We see that happening every day.

Mr. Tierney. Mr. Lynn, what do you say to that? How does your organization respond to that?

Mr. Lynn. I don't think there is any doubt that the patient care delivery system needs to be redesigned. It is complicated in that many of the nurses who practice in our environment learn primary nursing, one-on-one patient relationships. It is clear now that in a shortage situation like we face, that a more team-based approach is needed.

Mr. Tierney. I am sorry. I have to go back. I am hearing a mixed message. I am hearing there is no shortage of people who want a nursing career, and no shortage of people that are nurses. There are instead people that are leaving because they don't like the conditions. I want to try to reconcile that and what your organization does to reconcile that.

Mr. Lynn. The nurses that we need in the in-patient care setting are not there in sufficient quantities. They have taken other opportunities. So part of the problem is getting people in the pipeline, getting students to elect nursing, and improving the compensation benefits in the working environment for those nurses in direct patient care.

Mr. Tierney. What is your organization doing about the latter part of that?

Mr. Lynn. We are working with nurses to redesign nursing unit patient care delivery systems to reduce the amount of paperwork that they need to prepare, and to provide them more support in the patient care setting, such as more caregivers, more hands, more support within the patient care delivery team, by moving into models where the care delivery team really functions as a team and supports each other.

Mr. Tierney. Are you doing anything with respect to hours of work, such as mandatory overtime and issues like that?

Mr. Lynn. Mandatory overtime, in my experience, is not commonplace.

Mr. Tierney. I can tell you in my district, it is absolutely commonplace. All the hospitals in my area are hard-pressed, and it is the number one issue of the many nurses that come in to talk to me about it. So I am not sure why it hasn't infected your area yet, and maybe I should have them write your organization. I think they want the expertise and the attention of your AHA in helping them address this problem. I think it is going to be necessary.

Mr. Lynn. Mandatory overtime, as I am familiar with it, is a tool of last resort. It is a way that after all other methods have been exhausted, which includes calling people that are on the on-call schedule, working through your in-house pools and working through outside agency contracts. If there is no other way to staff a unit, and that unit is vital, then mandatory overtime is used.

Mr. Tierney. In fairness, sometimes it is mandatory, as you say. Sometimes it is the pressure people put on themselves. Many of these nurses simply will not refuse to answer the call, because they know that it means one of their peers is going to be left shorthanded, and the patient is going to be left without service. I don't mean to say you are badgering people, but more often than not they know the rest of that shift is going to be shortchanged, and there are patients going without the kind of care they need. I think you have to look at it in terms of that, too.

Mr. Lynn. I think you may be referencing a pocket where there is a particular problem, but I don't think it is a widespread issue across the country. I think there are communities that have a higher vacancy rate than others. Our vacancy rate runs about half the national average, so it hasn't become a huge issue for us, and we don't have problems when we ask people to work additional hours. September 11 was a great example. We had more staff than we possibly could have used that day.

Chairman Boehner. [Presiding.] The Chair recognizes the gentleman from North Carolina Mr. Ballenger.

Mr. Ballenger. Ms. Foley, my home hospital in North Carolina is a Magnet hospital. I am very proud of that. I would like to thank you and Ms. McCullough for your efforts in getting the needle stick bill passed.

I would like to ask a question because I know in my home area, we have been able to hire a lot of Canadian nurses. Is there a large disparity between the pay scale in Canada and the pay scale in the United States?

Ms. Foley. I think for a period of time, Canadian nurses found the U.S. quite attractive and had ease migrating to this area. However, the Canadian Nurses Association and the country are now asking their nurses to stay home. They have a 60,000-nurse shortage out of about 240,000 registered nurses. So their country is being affected as well.

Mr. Ballenger. If I may we are running out of time. I wanted to ask Ms. Bartels a question, and it would apply to Ms. Garner, too.

In my area, because of the shortage that we know we are going to face and so forth, we got the University of North Carolina, Appalachian State University, our community college and a private college together in three out of four nursing programs. However, one of them is 60 miles away, one is 40 miles away, and the community college is completely filled. We can't put any more kids in there.

We did a poll, and we found out that we had a lot of people who would like to be nurses, or ex-nurses that would like to go back to work, but they don't want to go for training 50 or 60 miles away. Is distance learning a practical alternative to educate a person to become a nurse?

Ms. Bartels. Absolutely. The State of Georgia has done quite a bit of that, and our particular school is doing a significant amount with distance learning, both asynchronous learning and Web-based learning. We have always done that with our RN to BSN programs and with our graduate program. We are looking at doing it with our undergraduate program as well using preceptorships.

We face the same problems in rural Georgia. We have had opportunities to do partnerships with institutions that have decided, based on staffing criteria, that they would like to have programs brought to them. So we are doing a combination of distance learning initiatives with four pre-licensure students, those without a credential, combining distance learning through a system wide Georgia network to do core requirements.

Mr. Ballenger. I don't want to interrupt you, but my time is running out. I've got to go vote. I would like to ask a question. Would it be possible to get information along those lines to my area of North Carolina?

Ms. Bartels. Absolutely.

Mr. Ballenger. And, Ms. Garner, I hate to cut you off, but I am going to be short on my vote. Thank you very much.

Chairman Boehner. You are not going to be as short as the Chairman and Mr. Scott, who are going to finish up. Do you have anything else?

Mr. Scott. I ask unanimous consent that the statement from the gentleman from New Jersey, Mr. Holt, be entered into the record.

Chairman Boehner. Without objection, so ordered.

Let me thank the witnesses for your testimony and apologize to you that from time to time when we schedule hearings, we have recorded votes on a host of issues, and today was one of those days. We usually treat our witnesses much better than you have been treated. So accept our apologies, and with that, thank you for your testimony, and the hearing is adjourned.

Whereupon, at 1:50 p.m., the Committee was adjourned.

APPENDIX A - WRITTEN STATEMENT OF CHAIRMAN JOHN BOEHNER, COMMTITEE ON EDUCATION AND THE WORKFORCE

Statement of the Honorable John Boehner

Chairman

Committee on Education and the Workforce

September 25, 2001

Good morning. Thank you for joining us for this important hearing. Today the Committee is meeting to hear testimony on the nursing shortage facing our country. As most of you know, this hearing was originally scheduled to take place two weeks ago today -- September 11th. Among the many things we have awoken to since that fateful day is the importance of the women and men who make up our nation's medical and emergency professions. If the nursing shortage facing our country was in serious condition two weeks ago, its condition is critical today.

Two weeks ago today we watched dedicated nurses and other medical personnel selflessly respond to the tragic events in New York City and at the Pentagon. Today we have with us on our panel, and in our audience, nurses who were there to care for others in that time of need. We thank you for your willingness to join us today and for your dedicated response in that emergency. And, more than that, we are grateful to you, and to all of your colleagues, for your chosen profession.

The "choice" of nursing is at the heart of what we examine today.

If ever an issue demonstrates the lifeblood connection between education and the workplace – this is certainly it. Nurses make up the backbone of our health care system. They provide much of the direct care all of us receive. Nursing requires exacting and continuing education and skill. While we all know that nursing can be one of the most rewarding professions, at the same time it can be one of the most mentally and physically demanding careers one can choose.

And so today, we will examine the causes and impact of the nursing shortage. We expect to hear about innovative remedies currently being undertaken by education institutions and the health care industry, as well as suggestions for further action.

I want to thank our witnesses for coming today and giving us the benefit of their perspectives and expertise on this issue. I especially want to acknowledge the appearance of our colleagues, Congresswoman Kelly and Congresswoman McCarthy, who will testify on our first panel today.

Let me provide some additional context for our hearing today.

Like many of you, I regularly hear from hospitals in my district about the difficulty they are having in recruiting and retaining nurses. While the individual stories are different, the themes remain the same. Demand for nurses continues to increase as the population served ages and acuity levels of patients increase. At the same time, nurses are leaving the hospital setting for other opportunities. While hospitals are making changes to the nursing workplace to make employment more attractive, recruitment efforts have not succeeded in filling all of the empty positions. As a result, staffing challenges are exacerbated.

In addition, the nursing workforce is aging, and fewer new nurses are entering the profession to replace those who are retiring or leaving. The average age of a nurse now is just over 43 years. Unfortunately, fewer young people are choosing to pursue a career in nursing, and enrollment in all nursing education programs has declined. Certain populations remain under-represented in the nursing field, including men and minorities. Hospitals are experience tremendous vacancy rates for nursing positions. Overall, the pipeline of new graduates from nursing programs is insufficient to keep pace with demand.

While providers in many areas of the country say they currently face a crisis, the shortage is only expected to worsen. By 2020, as the baby boomers reach their late 60s and 70s and need more health care, the nursing workforce is projected to fall to nearly 20 percent below projected need.

Now, we have new issues that may impact the profession. For instance, we do not yet know whether or how many nurses in the military reserves may be called into active duty. In addition, recent events have forced us to evaluate our emergency preparedness around the country. Clearly, this situation must be addressed.

Through this hearing, I hope we will bring needed attention to the growing shortage and provide a venue for an exchange of ideas on possible solutions. Strategies to address the nursing shortage could impact education, training, and workplace programs.

I anticipate that we will learn that there are no easy solutions to address this situation. However, our discussion today likely will reinforce the fact that all parties – educators, nurses, employers, and government – need to work together to reach out to young people and under-represented groups to encourage them become nurses and to keep current nurses working in the profession. I look forward to hearing the suggestions of our witnesses.

APPENDIX B - WRITTEN STATEMENT OF CONGRESSWOMAN SUE KELLY, 19TH DISTRICT OF NEW YORK, U.S. HOUSE OF REPRESENTATIVES

Testimony of the Honorable Sue W. Kelly

Before the Committee on Education and the Workforce

September 25, 2001

Thank you Mr. Chairman and distinguished Members of the Committee for inviting me to testify about the nursing shortage, a growing problem with the potential to impair health care delivery in our nation. I am pleased that the Committee has recognized the severity of this issue and convened this hearing.

No doubt you have heard recently from hospitals, skilled nursing and long-term care facilities in your districts, about the difficulty they face in filling their nursing staff slots. This crisis is real. I've seen it in hospitals in my district and I appreciate the opportunity to appear here today to discuss both short and long-term solutions to this problem.

Now more than ever attention is focused on the ability of health care personnel to respond to critical patient needs. Our nation's nurses are among the many heroes who responded to the recent attacks on the Pentagon and the World Trade Center. The New York Nurses Association reported overwhelming support from nurses in New York and around the country who volunteered to care for victims and rescuers. In New York City, at "ground zero," I have met and spoken with nurses who rushed to work there on their days off after hearing of the attacks. This sort of selfless service defines the nursing profession.

Nursing is a tough job, both mentally and physically. Nurses put their own health and safety at risk daily in the course of their jobs. Nursing can be a very rewarding profession. Unfortunately, I have heard from many nurses that they would not recommend the profession to friends or family unless major changes take place in the industry.

The shortage of nurses in our nation's hospitals and the pending retirement of many RNs, should be worrisome to us all. Hospitals cannot run without nurses. RNs comprise the largest group of health care providers. Without adequate nursing staff, hospitals are forced to close units, turn away patients and redirect emergency cases. This results in long waits and reduced quality of care. In critical situations, timing is everything, and when patients have to travel farther, or wait longer for care, they are less likely to have a positive recovery.

The average age of nurses in New York is 48 and the average retirement age is 52. The number of nurses approaching retirement coupled with the aging baby boomer generation who will require care, only increases the need for nurses. Looking down the road, the population of those age 65 and older is expected to double in the next 30 years. The cumulative effect of all of this is that nurses are leaving the profession rapidly, at a time when we need them most. It is imperative that we focus on solutions that will bring more nurses into our health care facilities and faculty to our nursing schools.

I am introducing new legislation aimed at combating the nursing shortage. I am collaborating in this effort with Senators Tim Hutchinson and Barbara Mikulski, who have already introduced a version of the Nursing Employment and Education Development Act, or the NEED Act. In short, the NEED ACT provides a framework for increasing awareness of opportunities in the nursing profession, growing the enrollment in nursing schools, and providing staff coverage for areas experiencing more acute shortages.

The NEED Act expands existing nurse loan repayment programs and establishes a Nurse Service Corps so nurses can receive scholarships in exchange for postgraduate service in a geographic areas experiencing shortages. It expands the list of eligible entities at which they can fulfill this service requirement to include nursing homes, home health agencies, public health departments and nurse managed health centers.

The bill will focus on attracting students to nursing by educating them about the benefits of a nursing career. Grants for multi-media outreach and public awareness campaigns will help ensure adequate registration at nursing schools.

In order to retain and strengthen our existing nurse workforce, the NEED Act contains "career ladder" provisions to encourage nurses and nurse aides to pursue advanced degrees so they can increase the level of care they can provide. Additionally, the bill provides grants to encourage mentoring, internship and residency programs, as well as programs to bring former nurses back into the field.

The bill also contains provisions for fast-track faculty development at nursing schools so there are well-qualified nurse educators to replace those retiring. This provision encourages masters and doctoral students to expedite their studies through loans and scholarships.

Again, I commend the Committee for holding this hearing today in order to explore solutions to the nursing shortage. I look forward to the testimony of the second panel and to working with all Members of this Committee to get more nurses into our hospitals and secure the future of nursing. I am happy to answer any questions.

APPENDIX C - WRITTEN STATEMENT OF CONGRESSWOMAN CAROLYN McCARTHY, COMMITTEE ON EDUCATION AND THE WORKFORCE

Testimony of the Honorable Carolyn McCarthy

Before the Committee on Education and the Workforce

September 25, 2001

Thank you, Chairman Boehner and Representative Miller for this opportunity to testify before my colleagues on the Education and Workforce Committee. I have always been proud to serve on the Education Committee, but I am especially proud today because we are focusing on an issue that is very important to me personally and professionally.

Mr. Chairman, before coming to Congress, I spent 30 years as a nurse on Long Island, New York. And even now, I know that there isn't a better career in the than nursing or better training for being a Member of Congress. The only difference is now I have a lot more patients.

That's why I am particularly saddened when we talk about the nursing shortage. And let's be honest, right now we are in the middle of a national nursing shortage crisis. Of the estimated 2.5 million licensed nurses in our country, 400,000 have left the profession for other pursuits. In the year 2000 alone, Long Island had an 8% Registered Nurse vacancy rate and a dangerously low 16% Licensed Practical Nurse vacancy rate.

It's startling to learn that hospitals need about 126,000 nurses to fill all the nursing positions available today!

Mr. Chairman, the crisis will only get worse in the future. As the baby boom generation ages, the demand for more nurses will dramatically increase, as well. And like the general population, the nurse workforce is aging, while enrollment in nursing education programs have dramatically declined over the past five years.

Between 1995 and 1998, there was a 20.9% decrease in the number of people enrolling in nursing schools. In addition, enrollment in Bachelor of Science in Nursing programs was down 4.9% in 1999. This is especially troubling when taking into account that nurses have been leaving the field at record rates. The booming economy of the '90s increased job opportunities for practicing nurses. But reductions in Medicare reimbursements resulted in a shift from inpatient to outpatient care, leaving the most ill patients in the hospital, creating a more stressful environment for nurses who stayed in the field.

High-risk patient care areas such as the intensive care unit, the neonatal intensive care unit, and the emergency room, which require highly skilled nurses with significant experience have been affected the most by the shortage. As a nurse, I can tell you that getting the right care in the first 24 hours of being in an intensive care unit can make all the difference in whether or not you recover from life-threatening problems. Further, if you do survive, the kind of care you receive in the first 24-to-48 hours dictates how long your recovery will take.

When I speak to health care professionals or visit hospitals in my district, I hear the same thing from nurses I meet: "I love my job, but the sacrifices I make are too great." Let's be honest – nobody ever went into nursing to make money, but like our teachers, they deserve better.

And like teaching, nursing has traditionally been a profession made up mostly of women. In 2000, less than 6% of nursing positions were held by men. Over the past 20 years, professional opportunities for women have grown greatly. Many women who years ago would have gone into nursing in the past are now breaking new ground in technology, business, and politics. Unfortunately, what hasn't changed over the last 20 years is how much we pay our nurses.

Nurses go into the field because we want to help people – we want to make a difference in their lives. One thing nurses will not tolerate is inferior care to their patients. Unfortunately, that's exactly what happens when a hospital is short-staffed; it is impossible to give quality care to patients.

Mr. Chairman, I want to focus on two types of nurses to give you a more in-depth look at the professionals we have working in the health care field.

Registered nurses (RNs) and Licensed Practical Nurses (LPNs) are responsible for a large portion of health care provided in this country. RNs make up the largest group of health care providers, and, historically, have worked predominantly in hospitals. A smaller number of RNs work in other settings, such as ambulatory care, home health care, and nursing homes. Their responsibilities may include providing direct patient care in a hospital or a home health care setting, managing and directing complex nursing care in an intensive care unit, or supervising the provision of long term care in a nursing home.

LPNs make up the second largest group of licensed health care givers and primarily provide direct patient care under the direction of a physician or RN. Both RNs and LPNs are subject to state licensing requirements.

Individuals usually select one of three ways to become an RN – through a two-year associate degree, a three year diploma, or a four year program. LPN programs are 12 to 18 months in length and generally focus on basic nursing skills, such as monitoring a patient resident condition, and administering treatments and medications. In short, Mr. Chairman, all these men and women are professionals and should be treated as such.

Mr. Chairman, we have outlined the problem, now, what about the solutions? There are many things we can do to combat worker shortages. First, we need to recruit qualified, dedicated students. Our students have so many choices for careers today, we need to make nursing a competitive option. One way to do this is to increase funding for the Nurse Loan Repayment Program and designate the income as non-taxable.

We need to further increase reimbursement rates to hospitals, so they can increase nursing salaries. If nurses were compensated as other professionals, more students will want to enter into the profession.

Lastly, we have to create incentives for nurses to stay in nursing upon training completion. We should provide grants to encourage nurses to upgrade their skills in clinical specialty areas that have shortages. We must work with our hospitals to improve working conditions for our nurses.

Mr. Chairman, solving the nursing shortage is not just the right thing to do for our nurses, it's the right thing to do for health care in America.

APPENDIX D - WRITTEN STATEMENT OF MELISSA VELAZQUEZ, RN, BURN INTENSIVE CARE UNIT, WASHINGTON HOSPITAL CENTER, WASHINGTON, D.C.

Testimony of Melissa Velazquez, RN

Before the Committee on Education and the Workforce

September 25, 2001

Good morning, everyone. My name is Melissa Velazquez, and I'm a registered nurse in the Burn Intensive Care Unit at the Washington Hospital Center. Thank you for offering this tremendous opportunity to speak to you today.

The spirit that we have seen across the nation has been nothing less than astounding. The willingness of Americans to take care of their families, their friends, their neighbors, communities and ultimately their nation is overwhelming. It is something that you see and feel everywhere you go. If there is one thought that I absolutely want you to take home today, it is that spirit has been alive, well and thriving in the profession of nursing since its inception. Not only in the Burn Intensive Care Unit, where we have been given the bittersweet privilege to care for the men and women injured at the Pentagon, but in hundreds of clinical settings all over this country, from the home to the hospital, nurses give 110% of themselves everyday they walk through the doors of their facilities.

As the events of that day evolved, my priorities changed. I collected my daughter from school, got home safe and made the phone calls necessary to make sure my family was okay. I called my head nurse and she asked if I could come in that night. Of course, the answer was yes.

In all honesty I was expecting absolute mayhem. The only other previous experience I had remotely similar was Memorial Day two years ago. Five DC firefighters were injured in a house fire, three of which lost their lives. The flurry of activity that night was unlike any other. But much to the credit of all that were involved that day of the attack, when I arrived that evening, seven of the eight burn victims from the Pentagon were settled in. To lend some perspective to that, for just one large burn victim it takes one doctor, one respiratory therapist and two to three nurses - not to mention ancillary support from other departments (lab, pharmacy, radiology) - a minimum of two to four hours to settle a patient in and that's if nothing goes wrong. The members of the burn team that were there that day did it seven times over in a phenomenal amount of time.

How is that possible? WHC is experiencing the same nursing shortage the rest of the country is. Where did the extra nurses come from?

Over the last year, the Burn ICU lost more than half of their staff to different education and employment opportunities. They weren't satisfied that the necessary changes in the work environment were being made. Why do I mention this? Because those same nurses that left were some of the same nurses that you saw on the unit the day of the attack and in the weeks following. Why? Because we're nurses, that's what we do. In a time of need, we put away any differences we have and do the task at hand. Their example speaks volumes to the spirit of the nursing profession.

The eighth burn victim hadn't arrived yet. This was to be my patient, a lieutenant in the United States Navy. Before I go on, be assured that I spoke with the lieutenant, his wife and his mother and gained their permission to talk about him today. Although I will not discuss any of his injuries, there are a few things that stand out in my mind. His wife arrived on the first night and spoke of her love for him and cried; then she pulled herself together because her husband needed her.

Severe burn victims experience tremendous swelling, and the lieutenant's eyes were swollen shut. On the second night, I was applying ointment to his eyes and he opened them on his own. I went running out to call his wife to come in to see him. I said to the lieutenant, "Your wife is here; show her what you can do!"

Last weekend, I was with him when he sat in a chair and when he walked on his own to the tank for changing his dressing.

As a nurse I have the honor of sharing these moments with the lieutenant and his family. These are the singular moments that make RNs' hearts sing. As long as these moment outweigh the decline of the working environment, I'll keep coming back.

APPENDIX E - WRITTEN TESTIMONY OF LISA TOMPKINS, RN, BSN, TRAUMA/NEURO INTENSIVE CARE UNIT, INOVA FAIRFAX HOSPITAL, FALLS CHURCH, VA

Testimony of Lisa Tompkins, RN, BSN

Before the Committee on Education and the Workforce

Tuesday, September 25, 2001

Good morning Mr. Chairman and Members of the Committee. My name is Lisa Tompkins , a registered nurse who works in the Trauma/ Neuro ICU at Inova Fairfax Hospital. It is an honor to be here today to share with you some of the key issues about the nursing shortage that currently faces our nation.

On September 11, I stood side by side with my nursing and healthcare colleagues across the country, in a high state of readiness in the face of one of the worst disasters this country has seen. The Inova hospitals, like the rest of the hospitals across this region, including New York and Pennsylvania, went into disaster preparations in the hopes of being ready to accept and treat patients who needed our care. My fellow nurses and other healthcare providers poured into our facilities, many on their days off, to assist. The Inova Alexandria Hospital saw 23 victims from the Pentagon site; Inova Fairfax, Fair Oaks, and Mount Vernon Hospital readied themselves by preparing inpatient beds, surgical suites, and emergency services to be ready for whatever situation presented. Like every nurse in the northern Virginia and DC region, our only wish was that we could have done more. We were connected in spirit to our fellow nurses in New York, as they stood ready at the doors of their hospitals, and in the streets, to treat those injured in the attack.

The event underscores a need to insure the continued and adequate supply of a competent and well-trained nursing workforce in the years to come. Health care institutions across the nation are experiencing a crisis in nurse staffing, and we are standing on the precipice of an uncertain future about our nursing workforce.

The causes of the nursing shortage are increasingly known and include an aging nursing workforce, a decrease in nursing school enrollment, a poor image of nursing as a career, and job intensity. The work is rewarding, demanding, and at times exhausting.

It is a distinct honor to share information about my experience as a nurse, and some innovative solutions that I see on the unit where I work.

My clinical background is 5 ½ years in critical care nursing. In May, I will be completing my masters' degree in nursing, funded by my employer. My clinical competencies include ACLS certification, certification in Trauma Nursing, expertise in the care of patients with ventriculostomies, continuous cardiac output monitoring, continuous bedside dialysis, and trauma resuscitation response to the emergency department. I care for one to two patients each shift I work and coordinate the multiple disciplines of care required for a critically injured trauma patient. The patients require a high level of clinical excellence, psychosocial skills and physical labor.

I stay in nursing because everyday is different and presents new challenges. I also have the honor of being able to truly affect lives every day in my work. I choose to stay in my unit for numerous reasons. We do our own scheduling, which allows for a large amount of flexibility. We have self-governance, letting staff participate in all levels of decision-making. We have a clinical ladder program that offers promotions and pay increases for levels of clinical excellence at the bedside. We are reimbursed for education and conferences. There is a great environment of learning with clinical autonomy and a climate of trust with our physicians. The unit has a strong culture of teamwork and respect, which keeps me going on the hard days, which there are plenty of. Hospital nursing is very hard work that does not close for nights, weekends and holidays. I work in a great unit with a low vacancy rate, yet we are not exempt from the troubles that are seen by nurses throughout the nation. Sick calls, short staffing, difficult patient assignments, use of agency nurses, and a desire for increased financial compensation are daily issues. I love what I do, and my hope for the next generation of nurses is that we address these issues today so that they can continue to provide outstanding care tomorrow.

Creating a National Agenda

There are many ideas for solutions, and I would like to emphasize just a few:

> **Focus on increasing the number of nurses that enter into practice** and advancing careers internally through scholarship money.
>
> **Improve the image of nursing** so that it is seen as a desirable profession. This can be accomplished through a national media campaign, sponsoring youth programs like summer camps, requiring school experiences in healthcare, and career counseling for youth.
>
> **Transform the role of the RN** – We need to figure out how to support nurses in their work at the patient bedside. This may mean recrafting the role of the nurse to meet the increased technological demands with the inevitable decrease in supply of nurses.
>
> **Hospitals and healthcare systems could create environments consistent with the Magnet Hospitals** (American Nurses Credentialing Center) that have shared leadership, flexible scheduling, competitive salaries and benefits, high percentage of BSN and MSN nurses, adequate staffing, excellent continuing education programs, and support for new graduate nurses.

I believe what nurses need is a combination of attention to the "hard stuff" which includes salary, benefits and scheduling, as well as the "soft stuff" of culture, leadership, and education and development.

APPENDIX F - WRITTEN STATEMENT OF MARY FOLEY, RN, MS, PRESIDENT, AMERICAN NURSES ASSOCIATION, WASHINGTON, D.C.

Testimony of Mary Foley, RN, MS

Before the Committee on Education and the Workforce

September 25, 2001

Good morning Mr. Chairman and Members of the Subcommittee, I am Mary Foley, MS, RN President of the American Nurses Association. ANA is the only full-service association representing the nation's registered nurses (RNs) through its 54 constituent nurse member associations. Our members include RNs working and teaching in every health care sector across the entire United States. I myself have more than 25 years experience as a staff nurse, a nurse executive and a clinical instructor in nursing.

Today, health care institutions across the nation are experiencing a crisis in nurse staffing, and we are standing on the precipice of an unprecedented nursing shortage. Let there be no doubt about it, the current and emerging shortage of RNs poses a real threat to the nation's health care system. RNs are the largest single group of health care professionals in the United States; we underpin the entire health care delivery system. Concerns that we have all been hearing about the current nursing shortage underscore the fact that having a sufficient number of qualified nurses is critical to the nation's health.

The emerging nursing shortage is very real and very different from any experienced in the past. Hospitals, long term care facilities and other health care providers across the nation are having difficulty finding experienced nurses who are willing to work in their facilities. Press reports about emergency department diversions and the cancellation of elective surgeries are becoming commonplace. Nurses are reporting that understaffing is jeopardizing patient care. In addition, projections show that these current shortages are just a minor indication of the systemic shortages that will soon confront our health care delivery system.

It is important to realize that the causes for, and therefore the answers to, this emerging nursing shortage are complex and interrelated. A comprehensive approach to this problem must contain programs designed to improve nurse education, health delivery systems, and the environment in which nurses work. To this end, leaders of national nursing organizations are currently attending a four-day summit in the DC area. This *Call to the Nursing Profession,* has been convened to enable nursing organizations to develop a comprehensive plan to ensure that patients continue to receive safe, high-quality nursing care; to retain experienced nurses in the profession, and; to recruit more people into the profession. No answer will be complete unless it addresses all of these components.

Recent Changes in Nurse Employment

Current staffing problems are inexorably tied to changes in nurse employment practices. Therefore, I will provide brief overview of changes in nursing employment over the last decade. Just ten years ago we were emerging from the nursing shortage of the late 1980's. At that time, nursing workforce issues had caught the attention of the highest reaches of the Reagan and Bush Administrations. The HHS Secretary's Commission on Nursing developed a list of 16 recommendations on methods to address the shortage. Very few of the workplace initiatives contained in this report were actually implemented. However, health care facilities across the nation did institute aggressive nurse recruitment campaigns, federal funding for nursing education was increased, and nurse wages were raised. At the same time, RN employment in hospitals grew by a steady rate of 2-3 percent annually through the 1980's and early 90's. By the early 1990's reports of nurses shortages had significantly diminished.

However, in the mid-1990's, the picture changed. At this time, the new Medicare prospective payment system and increased cost savings measures instituted by managed care began to exert downward pressure on reimbursement. Faced with decreasing margins, providers eagerly sought out and implemented programs designed to reduce expenditures. New models of health care delivery were implemented, and highly-trained, experienced - and therefore higher paid - personnel were eliminated or redeployed. As RNs typically represent the largest single expenditure for hospitals (averaging 20 percent of the budget), we were some of the first to feel the pinch.

Analysis of census data shows that between 1994 and 1997 RN wages across all employment settings dropped by an average of 1.5 percent per year (in constant 1997 dollars). Between 1993 and 1997, the average wage of an RN employed in a hospital dropped by roughly a dollar an hour (in real terms). RN employment in the hospital sector reversed to the negative, and reports of lay-offs became common as lesser-skilled, lower-salaried assistive staff were hired as our replacements. Many providers eliminated positions for nursing middle managers and executive level staff. Hospital employment for unlicensed aides, however, increased by an average of 4.5 percent a year between 1994 and 1997.

The overall impact of the changes in the 1990s was to increase pressure on staff nurses who were required to oversee unlicensed aides while caring for a larger number of sicker patients. The elimination of management positions shortened the career ladder and decreased the support, advocacy and resources necessary to ensure that nurses could provide optimum care. At the same time employment security was uncertain and wages were being cut.

The Current Employment Situation

Not surprisingly, the rapid deterioration in the RN employment environment precipitated a downturn in the number of people working in the nursing profession and growing discontent among those who remain. As the image of professional nursing has changed from a field that offered many opportunities and high job security to one that holds great uncertainty, relatively low wages and difficult working conditions, students have shied away from nursing programs. The number of students entering nursing school has dropped consistently and dramatically through the mid-to-late 1990's. Nursing schools responded by reducing the number students they accept and the number of faculty that they employ.

A recent ANA survey of nurses revealed that nearly 55 percent of the nurses surveyed would not recommend the nursing profession as a career for their children or friends. In fact, 23 percent of the respondents indicated that they would actively discourage someone close to them from entering the nursing profession. In fact, it is common for nursing students to be approached by experienced nurses who advise them to find another occupation - one that is less stressful and more highly esteemed.

A large multi-national survey recently conducted by the University of Pennsylvania's Center for Health Outcomes and Policy Research shows that America's nurses are particularly dissatisfied with their jobs. More than 40 percent of nurses in American hospitals reported being dissatisfied, as compared to 15 percent of all workers. In addition, this report shows that 43 percent of American nurses score higher than expected on measures of job burnout.

This job burnout leads the average American nurse to leave hospital employment after only four years. Unfortunately, many of these nurses are choosing to leave the profession altogether. The 2000 National Sample Survey of Registered Nurses shows that an unusually large number of nurses (500,000 nurses - more than 18 percent of the nurse workforce) who have active licenses are not working in nursing.

Recent reports by the General Accounting Office, the Congressional Research Service, academia and private market research indicated that job dissatisfaction is a major factor contributing to the current nursing shortage. Nurses are, understandably, reluctant to accept positions in which we will face inappropriate staffing, be confronted by mandatory overtime, be inappropriately rushed through patient care activities, and be unable to provide the high quality care that we were trained to give.

Solutions

ANA is working to address current nurse staffing shortfalls, to improve the work of nursing and to encourage more young people to enter the profession of nursing.

Adequate Staffing

The safety and quality of care provided in the nation's health care facilities is directly related to the number and mix of direct care nursing staff. More than a decade of research shows that nurse staffing levels and skill mix make a difference in the outcomes of patients. In fact, four HHS agencies - the Health Resources and

Services Administration, Health Care Financing Administration, Agency for Healthcare Research and Quality, and the National Institute of Nursing Research of the National Institutes of Health - recently sponsored a study on this very topic. The resulting report, released on April 20, 2001, found strong and consistent evidence that increased RN staffing is directly related to decreases in the incidence of urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding, and decreased hospital length of stay.

A recent ANA survey reveals that 75 percent of nurses feel that the quality of nursing care at the facility in which they work has declined over the past two years. Out of nearly 7,300 respondents, over 5,000 nurses cited inadequate staffing as a major contributing factor to the decline in quality of care. More than half of the respondents believed that the time they have available for patient care has decreased.

The University of Pennsylvania research shows that 70-80% of more than 43,000 registered nurses surveyed in five countries reported that there are not enough RNs in hospitals to provide high quality care. Only 33 percent of the American nurses surveyed believed that hospital staffing is sufficient to "get work done." This survey reflects similar findings from a national survey taken by the Henry J. Kaiser Family Foundation (1999) that found that 69 percent of nurses reported that inadequate nurse staffing levels caused great concern for patient care. We should all be concerned that more than 40% of the responding nurses in the ANA survey stated that they feel that the quality of care has suffered so severely that they would not feel comfortable having a family member or loved one receive care in the facility in which they work.

In addition to the important relationship between nurse staffing and patient care, several studies have shown that one of the primary factors for the increasing nurse turnover rate is dissatisfaction with workload/staffing. Adequate staffing levels allow nurses the time that they need to make patient assessments, complete nursing tasks, respond to health care emergencies, and provide the level of care that their patients deserve. It also increases nurse satisfaction and reduces turnover. For these reasons, ANA supports efforts to require acute care facilities to implement and use a valid and reliable staffing plan based on patient acuity. In addition we support efforts to enact upwardly adjustable, minimum nurse to patient staff ratios in skilled nursing facilities.

Mandatory Overtime

Nurses across the nation are also expressing concerns about the dramatic increase in the use of mandatory overtime as a staffing tool. We hear that overtime is the most common method facilities are using to cover staffing insufficiencies. Employers may insist that a nurse work an extra shift (or more) or face dismissal for insubordination, as well as being reported to the state board of nursing for patient abandonment.

The use of mandatory overtime is not as uncommon or isolated as some would have you believe. In fact, the term 'mandation' has been coined by the health care industry to describe this staffing tool. A recent ANA survey (sample size of 4,826) revealed that two-thirds of nurses are being required to work some mandatory or unplanned overtime every month.

Our concerns about the use of mandatory overtime are directly related to patient safety. We know that sleep loss influences several aspects of performance, leading to slowed reaction time, failure to respond when appropriate, false responses, slowed thinking, and diminished memory. In fact, 1997 research by Dawson and Reid at the University of Australia showed that work performance is more likely to be impaired by moderate fatigue than by alcohol consumption. Their research shows that significant safety risks are posed by workers staying awake for long periods. It only stands to reason that an exhausted nurse is more likely to commit a medical error than a nurse who is not being required to work a 16 to 20 hour shift.

Nurses are placed in a unique situation when confronted by demands for overtime. Ethical nursing practice prohibits nurses from engaging in behavior that they know could harm patients. At the same time, RNs face the loss of their license - their careers and livelihoods - when charged with patient abandonment. Absent legislation, nurses will continue to confront this dilemma. For this reason, ANA supports legislative initiatives to ban the use of mandatory overtime through Medicare conditions of participation.

We are working through the Medicare system because we believe that the abusive use of overtime promotes poor patient care and therefore is a matter of public health safety. Just as limits on work hours for airline pilots and truck drivers are enacted through transportation law, we believe that this matter should be handled through health law. On a more practical level, we also believe that Medicare provider contracts cover more nurses in more facilities than an amendment to the Fair Labor Standard Act would.

Health and Safety:

As this Committee is aware, nurses are also leaving the profession due to avoidable injuries sustained on the job. This Committee took the lead last year in addressing one of the most devastating threats facing nurses and other health care workers - the threat of infection from contaminated needles and sharps. Your support and hard work on behalf of the Needle stick Safety and Prevention Act will save the lives of countless nurses and health care workers. An ANA survey of nearly 5,000 nurses that was released last week reveals that 80 percent of facilities are now providing safe needle devices for injections, IV insertions, and taking blood. This represents an incredible accomplishment for such a short period of time. ANA is confident that we will reach full compliance in the near future. On behalf of the 2.6 million registered nurses in America - thank you.

I wish I could report that our concerns about workplace health and safety are now solved. Unfortunately, the new ANA survey shows that health and safety concerns continue to play a major role in nurse's employment decisions. In fact, 88 percent of the nurse respondents reported that these concerns influence decisions about what type of nursing work they will perform. The top-ranking concerns are focused on the acute and chronic effects caused by overwork and fatigue, the risk of a disabling back injury, and the threat of sustaining an on-the-job assault. Government statistics show that nurses are more likely to sustain back injuries than heavy construction workers. In fact, studies of back-related workers compensation claims reveal that nursing personnel have one of the highest claim rates of any occupation or industry. Three of the top seven occupations at greatest risk for musculoskeletal disorders are health care occupations where the workers perform repetitive patient handling tasks.

The threat of on-the job violence is just as real. More than half of the respondents to the ANA survey reported being threatened or verbally assaulted in the last year, 17 percent reported being physically assaulted. Unfortunately, emergency department nurses are subjected to the same violence that brings patients into their care, and nurses in psychiatric facilities may be left unprotected from the most unstable and violent patients.

The public at large should be alarmed that the nurses who took part in the ANA poll responded overwhelmingly (75.8%) that unsafe working conditions interfere with their ability to deliver high quality care. We can do better than this. Our nurses and their patients deserve more. ANA is committed to continuing our work with this Committee, employers, and other health workers to find effective, common-sense, cost-effective solutions to these concerns.

National Labor Relations verses Kentucky River Community Care

In this time of deteriorating working conditions and increased stress, it is important that nurses maintain their ability to use collective bargaining to improve their working environment. Nurses are using this tool to curb the use of mandatory overtime, stem the inappropriate use of unlicenced assistive personnel, and to improve on-the-job safety.

ANA was disappointed when the U.S. Supreme court ruled this spring that six registered nurses at a Kentucky facility met the definition of 'supervisor' and are therefore ineligible to join a union or participate in collective bargaining. A split court upheld an the Sixth Court of Appeal's decision that these nurses met the definition of supervisor because they use independent judgment to direct the work of others. ANA concurs with the National Labor Relations Board in our belief that the court applied an unreasonably broad definition of supervisor in this case.

RNs regularly delegate certain patient care tasks to lesser-skilled assistants (e.g. assistance with bathing) in order to focus on other tasks that require more advanced skills (e.g., administering IV medication). Such delegation is governed by state laws and regulations, federal regulations, and the facility's own policies. The mere fact that a nurse directs these tasks does not mean that he or she has the ability to hire, fire, promote or discipline these employees. Therefore, the ability of staff RNs to direct the work of others should not be confused with the management-sanctioned authority that true supervisors exercise over the professional lives of employees.

ANA believes that the broad definition of supervisor contained in the National Labor Relations Act will continue to prompt unnecessary litigation and will interfere with the ability of many staff RNs to organize. We look forward to working with this Committee to craft a definition that contains a more appropriate definition of supervisor.

The Emerging Nurse Shortage

Traditionally, nursing shortages have been successfully addressed by changes in the market for nursing care. Health care facilities have normally responded to such shortages by instituting recruitment campaigns and increasing compensation. These actions served to attract more people into the profession, and to bring back those who had left. Unfortunately, the answer is not going to be so easy this time.

Today's staffing shortage is compounded by the lack of young people entering the nursing profession, the rapid aging of the RN workforce, and the impending health care needs of the baby boom generation. As new opportunities have opened up for young women and new stresses have been added to the profession of nursing, fewer people have opted to choose nursing as a career. New admissions into nursing schools have dropped dramatically and consistently for the past six years (the General Accounting Office reports a 20 percent decline in baccalaureate enrollments, a 11 percent decline in associate degree programs, and a 42 percent decline in diploma programs).

The lack of young people entering nursing has resulted in a steady increase in the average age of the working nurse. Today, the average working RN is over 43 years old. The national average is projected to continue to increase before peaking at age 45.5 in 2010. At that time, large numbers of nurses are expected to retire and the total number of nurses in America will begin a steady decline. At the same time, the need for complex nursing services will only increase. America's demand for nursing care is expected to balloon over the next 20 years due to the aging of the population, advances in technology and various economic and policy factors. In fact, the Bureau of Labor Statistics ranks the occupation of nursing as having the seventh highest projected job growth in the United States.

The increasing demand for nursing services, coupled with the imminent retirement of today's aging nurse, will soon create a systemic nursing shortage. A recent study published in the *Journal of the American Medical Association* estimates that the overall number of nurses per capita will begin to decline in 2007, and that by 2020 the number of nurses will fall nearly 20 percent below requirements.

Now is the time to address this impending public health crisis. ANA strongly supports the Nurse Reinvestment Act (H.R. 1436, S. 706) and the Nursing

Education and Employment Development Act (S. 721). These comprehensive bills addresses many issues in nurse education and will greatly aide recruitment into the profession. The combination of innovative recruitment techniques, curriculum support, scholarships, and loan repayments contained in these bills will enhance all aspects of nurse education. ANA urges this Committee to support the further development of our nation's existing nurse population and the cultivation of our youth into this very worthwhile profession.

Immigration

ANA has deep concerns about the use of immigration as a means to address the emerging nursing shortage. Throughout a number of nurse shortages, immigration has been promoted as the standard "answer" by employers who have difficulty attracting American nurses to work in their facilities. We have been down this road many times before without success. There are a number of problems with increasing the immigration of foreign-trained nurses, following are just a few issues:

- The influx of foreign-trained nurses only serves to further delay debate any action on the serious workplace issues that continue to drive American nurses away from the profession. As I mentioned earlier, a Presidential task force called to investigate the last major nursing shortage developed a list of recommendations. These 16 recommendations, released in December, 1988, are still very relevant today - they include issues such as the need to adopt innovative nurse staffing patterns, the need to collect better data about the economic contribution that nurses make to employing organizations, the need for nurse participation in the governance and administration of health care facilities, and the need for increased scholarships and loan repayment programs for nursing students. Perhaps if these recommendations were implemented we would not be here today. Certainly, we will be here in the future if they are ignored. ANA strongly believes that we should not recruit foreign nurses when the real problem is the fact that the domestic health care industry has failed to maintain a work environment that is conducive to safe, quality nursing practice and that retains experienced American nurses in patient care.

- There are serious ethical questions about recruiting nurses from other countries when there is a world-wide shortage of nurses. The removal of foreign-trained nurses from areas such as South Africa, India, and the Caribbean deprives their home countries of highly trained health care practitioners upon whose skills and talents their countries heavily rely.

- In addition, immigrant nurses are too often exploited because employers know that fears of retaliation will keep them from speaking up. There are numerous, disturbing examples from our experience with the expired H-1A nurse visa. The INS Chicago District issued a $1.29 million fine against FHC Enterprises, Inc. for 645 immigration document violations. FHC, Inc. fraudulently obtained 225 H-1A visas which were used to employ Filipino nurses as lower-paid nurse aides ($6.50 per hour) instead of as registered nurses ($12.50 per hour). The Catholic Archdiocese of Chicago agreed to pay $50,000 in fines and $384,700 in back wages to 99 Filipino nurses who were underpaid. In Kansas, 66 Filipino nurses were awarded $2.1 million to settle a discrimination case in which the Filipino nurses were not paid the same wage rate as U.S.-born registered nurses at the same facility. These are just a few of the cases that have come to light over the last decade.

Conclusion

ANA maintains the current nursing shortage will remain and likely worsen if changes in the workplace are not immediately addressed. The profession of nursing will be unable to compete with the myriad of other career opportunities available in today's economy unless we improve working conditions. Registered nurses, hospital administrators, other health care providers, health system planners, and consumers must come together in a meaningful way to create a system that supports quality patient care and all health care providers. We must begin by improving the environment for nursing.

ANA looks forward to working with you and our industry partners to make the current health care environment conducive to high quality nursing care. Improvements in the environment of nursing care, combined with aggressive and innovative recruitment efforts will help avert the impending nursing shortage. The resulting stable nursing workforce will improve health care for all Americans.

ADDENDUM

Given the tragedy of September 11, and its direct impact on our health care system, the American Nurses Association (ANA) submits this addendum to our original statement. It is hard to find words that express the profound sorrow and compassion that we feel for those impacted by these unspeakable acts. In addition, we are profoundly grateful to the heroes who immediately responded in this time of need. They renew my faith in what is good in our nation.

The accounts that we are receiving from our affiliates in New York, New Jersey, the District of Columbia, and Virginia are truly moving. On that fateful Tuesday, nurses, like so many other courageous men and women, answered the call to provide emergency and disaster relief services in overwhelming numbers. You will hear some of these personal accounts today, and I am attaching to this addendum a small number of stories that we have received from the New York State Nurses Association. I urge you to take a moment to read these inspiring stories.

From Lucille Yip, who did not hesitate to throw on her scrubs and hop a ride on a New York City Sanitation Vehicle to report to the St. Vincent's emergency room, to the nursing students who set up a temporary hospital on Chelsea Piers, to Melissa Velazquez who rushed to treat the victims from the Pentagon, there are hundreds of unsung heroes in this national emergency. In addition, there are many more nurses willing to help our nation prepare for and respond to the coming war against terrorism. Congress can help us prepare for this effort.

Emergency Preparedness in the Short-Run

ANA urges Congress to help the nursing profession respond to the new challenges that face our nation. We reach out to you, the Department of Health and Human Services, the Veteran's Affairs Administration and the Department of Defense to help us increase training for emergency response. Specifically, America's civilian nurses need training in protocols for biological and chemical warfare and other weapons of mass destruction. With proper training, all of America's 2.7 million registered nurses can provide an effective first-line response to future national emergencies.

While the current and emerging nursing shortage has been under discussion for the last few years, the issue takes on a new urgency given the war effort. Just as in the Gulf War, the current activation of our military, national guard and reserves will have an impact on the civilian health care workforce. Nurse staff vacancies will be exacerbated by the necessary activation of military medical units. We must act now to assure that both the military and civilian health systems are adequately staffed.

ANA sees an opportunity to bring some of the 500,000 registered nurses with active licenses who are no longer working in nursing back into patient care. I have heard from a number of nurses who have left the profession who are willing to lend their considerable skills and experience to help with disaster response and other efforts. With support for clinical refresher courses and training in emergency protocols, it may be possible to bring thousands of nurses back to help meet the health care needs of our nation.

The Increased Importance of Long-Term Support for Nursing

In a sense, the American health system is fortunate to have this pool of "non-participating" RNs to draw from. These men and women represent more than 18 percent of the entire American nurse workforce. Not since the national nursing shortage of the late 1980's have there been so many nurses who have left the profession. I have faith that my colleagues will step up to meet the immediate needs of our nation.

However, current events only serve to highlight the importance of nurses in our health care system. The medical needs of this new world make it critical that we address the many factors that are causing the nursing shortage. There is no time for delay, we must start meaningful efforts to recruit and retain nurses in patient care.

I understand that the Secretary of Health and Human Services has recently released funds to support nurse recruitment and training efforts. In addition, both chambers of Congress are actively considering legislation authorizing new nurse education programs. ANA urges you to support these efforts. We look forward to working with you, the administration, the schools of nursing, and health care facilities to make sure that these nurse recruitment programs are successful.

However, education and recruitment alone will not solve this nursing shortage. ANA maintains that it is vital to improve the environments in which nurses work. As long as nurses remain disheartened by their work environments, as long as they discourage their friends and families from entering the profession, as long as the average length of hospital employment remains at a mere four years, the root cause of this shortage will remain unaddressed.

Nurses are called to the profession by a desire to provide compassionate care to people in need. No one becomes a nurse to make money. We are driven by a desire to provide caring and high quality health care. As long as unreasonable schedules, dangerous understaffing, and fears of institutional reprisal keep us from meeting this calling nurses will continue to leave the bedside. Nurses do not want to be a part of a health system that fails to meet the needs of patients.

ANA looks forward to working with you to make the current health care environment conducive to high quality nursing care. Improvements in the environment of nursing care, combined with aggressive and innovative recruitment efforts will help address the nursing shortage. The resulting stable supply of nursing care will support high quality health care for all Americans.

Attachment Received from the New York State Nurses Association Nurse's Accounts of the Terrorist Attack on New York

Comments from ER nurses at Saint Vincents Catholic Medical Center

Paul Shubinsky

Paul Shubinsky was at home on Long Island when he received a call from his mother. He immediately put on the news and then headed for the hospital.

"The bridges into NYC were closed and police had shut the Long Island Expressway (LIE) to everything but emergency vehicles. I approached the police at the barricades on the LIE, showed them my credentials, and they let me through."

"When I arrived at the hospital it was 1:30, and everything was prepared in disaster mode.

By that time, the towers had collapsed. Although we were prepared for critical patients, only one or two showed up. Most of those we saw were walking wounded, mainly police and firefighters injured by debris. We kept hoping they would find survivors. We were waiting and waiting, but no one showed up."

Nancy Issing

It was Nancy Issing's day off and she was home asleep when the first plane hit the WTC. A phone call from her brother about the crash woke her – in time for her to hear the second plane hit the south tower. Although her windows were closed and the air-conditioner was on, she could smell the smoke.

She hurried to the hospital arriving there before the first patient. Her nurse manager assigned her to be captain of the unit to take the most critical patients. "At first there was a surge of patients, mostly burns, smoke inhalation and respiratory problems. Some patients had burns over 90% of their bodies."

"Although the staff was frightened, it didn't affect anyone's performance. We have experience with disasters. At first I thought we might not be able to manage all the patients, but then it slowed down. By late afternoon we stopped getting patients."

"During the second day, we were seeing lesser injuries like eye irritation and breathing difficulties, mostly from rescue workers. We were desperate for patients. It was frustrating. It was horrible. All these trained workers, dedicated to helping people, and so many gravely injured, but we couldn't get to them."

Lucille Yip

LucilleYip lives on the 44th floor of a high-rise in Chinatown that looks out onto the New York skyline. The view is so wonderful that a New York TV station has a camera over her living room window to track traffic patterns. The night before the attack she says,

"I got up at 3:00 am and looked out the window and saw how beautiful everything looked. Then I feel asleep. At 9:00 am I heard a huge explosion and then sirens. I turned on the news, but I thought I must be dreaming, so I went to the window. I saw the towers on fire and then I saw them both collapse. There was a knock on my door and I was told to evacuate. I threw on my scrubs and went outside. There were hundreds of people hurrying through Chinatown, coming from the area around the WTC. They were covered with white soot.

I didn't know how I was going to get to work and tried to hitchhike. I saw a car with a NYC Sanitation Department identification. It had stopped to pick someone up, and I said, "I'm a nurse. I need to get to the ER." "Hop in," the driver said.

I worked in triage at one of the two entrances to the hospital ER The first injuries I saw were cuts and fractures. People had run and fallen down. There were also lacerations, smoke inhalations and eye burns.

By the second day we were seeing mostly rescue workers. I worked Tuesday through Friday. The most difficult thing was having to turn away dozens of family members looking for loved ones. We kept a list of every patient who came in. And I would look down the list for the name. They kept coming and coming with photos. I turned away at least 80 people. I kept hoping I could at least say yes to one of them.

Working in the ER was like being on Noah's Ark, so enclosed and cut off. We had one radio. Everything seemed surreal. I wanted to go to the site. I wanted to make it real. Late Friday night that's what I did. What you see on TV cannot compare with what is there. You have to multiply it by 100. Workers were taking pictures of the scene. I didn't need a camera. I'll never forget what I saw. Never.

Nothing prepares you for something like this, but I am so proud to be a nurse. From starting an IV to giving a woman a hug made me feel good, knowing I could give of myself in some way to those who have suffered such a loss."

Comments from Professors Taking RN Students on their First Clinical Assignment

Elizabeth Ayello
Clinical Associate Professor
Division of Nursing
New York University

Tuesday morning, 29 RN students at NYU were scheduled for their first day of clinical practice in medical-surgical care. When the terrorists struck, plans changed. "We did everything by the seat of our pants," said Dr. Ayello. She and her colleagues divided the students into groups. Ayello told the 12 in her group she was going to the Chelsea Piers to set up an Emergency Hospital. "Who wants to come? If you don't, it won't affect your grade."

All 12 students followed her to the piers where they set up a MASH unit, and began to treat people with chest pains, respiratory problems, eye irritations. "Some of my students stayed all night."

Although the students didn't have a lot of high level skills, Dr. Ayello said, "There is always something you can do. She told them, "You know how to talk to people and how to comfort people and those are important nursing skills."

Dr. Ayello was impressed with her students' performance. "We are so blessed to have these people in our profession. I am so encouraged about the future of nursing."

Melissa Offenhartz
Adjunct Professor
Division of Nursing
New York University

Melissa Offenhartz took her students to the WTC on Thursday where they set up a triage area, caring for firefighters suffering chiefly from exhaustion and respiratory problems. "They wanted to go and help. They were motivated and courageous and they had a wonderful ability to jump in, assess, and do what was needed"

The behavior of rescue workers and health care personnel at the WTC site seems to have affected people. "I had two calls today from people who wanted to become nurses," Offenhartz said.

APPENDIX G - WRITTEN STATEMENT OF SUE ALBERT, RN, MN, MHA, ASSISTANT DEAN OF ALLIED HEALTH, COLLEGE OF THE CANYONS, SANTA CLARITA, CA

Testimony of Sue Albert, RN, MN, MHA

Before the Committee on Education and the Workforce

September 25, 2001

STATUS AND FUTURE OF NURSING EDUCATION

My focus in this presentation is the status of nursing education in the community colleges. My background is in the California Community College system. I have been in nursing education in the California Community College system for 22 years and while I have practiced only in California, I am, well aware of the issues in nursing across the nation. There are many unique aspects of nursing education in the State of California but also many similarities to community colleges across the nation.

According to the American Hospital Association there are 126,000 unfilled nursing positions in hospitals alone. The need for nurses was slammed home to the American people on September 11. On that day and the days following we saw the images of the nurses waiting at emergency room doors to receive the crushed and burned victims of the vicious attacks. What the public won't see are the nurses who will be with these victims as they begin their long recovery. The people will not see the nurse at 2 in the morning trying to help these victims through their terrible physical and emotional pain. I feel it would be naive to believe that there will be no further attacks on the American soil. And as important as defense is, it is equally important that we stand ready to help more victims of terrorists attacks. This means that nursing education is every bit as important as military spending.

Currently, California Community College Associate Degree Programs (henceforth to be referred to as ADN programs) provide for approximately 70% of the nursing graduates each year for the State of California. They prepare these nurses at a cost to the state of approximately $4457 per Full Time Equivalent Student (FTES). This is compared to the $8,677 per student for California State University and $18,643 per University of California student. Our California Community College students pay $264 in tuition and fees compared to $1,428 in tuition and fees for the CSU students and $3,429 in tuition and fees for the UC students. Typically the ADN graduate performs as well as or better than the BSN graduates on the National Licensure Examination. This is the benchmark for measuring the success of a nursing program.

PASS RATES OF THE NCLEX RN LICENSURE EXAM BY DEGREE

Year	*Associate*	*BSN*	*Diploma*
1995	91.0	88.7	92.7
1996	88.9	85.9	91.2
1997	88.1	86.7	91.0

1998	85.0	84.6	87.8
1999	84.7	84.8	85.4
2000	83.8	83.9	83.4
Avg.	*86.9*	*85.8*	*88.6*

Table courtesy of American Association of Community Colleges.

The ADN programs have suffered a decline in enrollment. According to the California Board of Registered Nursing Annual Report, there were 462 applicant openings that were unfilled for programs across the state in 1999-2000. There has been a decline in applicants to a certain extent but one of the other reasons for these empty slots is that because of long waiting lists, 1 to 2 years to be admitted, many students apply to multiple programs. When their name comes up for admission, they have oftentimes entered a program elsewhere, or they have changed their minds and they are not ready to enter. At College of the Canyons, my program had 4 empty slots in 1999-2000. After allowing year-round applications, we now have 119 students on our waiting list. It will take them approximately 1½ to 2 years to be admitted to our ADN program. COC admits 48 students each year, 24 students per semester. We have no classrooms or instructors available for more students. There are similar waiting lists across California and across the nation. There are also decreasing numbers of openings available as other nursing programs close. For instance, University of Southern California is closing its Bachelor of Science in nursing program.

California has a special issue in nursing education. California Community Colleges have an "open access to all" policy. For nursing education at the Community College level, this means that interviews and point systems to identify the most likely to succeed in the program are not allowed. All students meeting the minimum requirements as described by the schools are allowed into the programs. This has resulted in increased attrition rates. Schools that had 3% attrition rates prior to 1992 now may have 40% attrition rates. I have seen nursing pinning ceremonies where less than 50% of the students on the stage actually completed the program in two years. What this means is that the few slots available are being filled by people who may have little chance of success. Once a slot is vacated, it typically stays empty.

Decreasing enrollment and increasing attrition rates have resulted in a decrease in the number of nursing graduates. This is a trend across the country. The table on US Educated NCLEX Candidates by Degree Type as published by the National Council of State Boards of Nursing shows a decline of 96,610 candidates in 1995 to 71,475 candidates in 2000.

US Educated NCLEX Candidates by Degree Type

Year	***Associates***	***BSN***	***Diploma***	***Other***	***Total***	***Total-Associates***
1995	57,908	31,195	7335	172	96,610	38,702
1996	55,554	32,278	6346	148	94,326	38,772

1997	52,396	31,828	5240	155	89,619	37,223
1998	49,045	30,142	3978	74	83,239	34,194
1999	45,255	28,107	3161	84	76,607	31,352
2000	42,665	26,048	2679	83	71,475	28,810

Source: National Council of State Boards of Nursing

It is also clear from this table that ADN programs produce almost twice the number of nursing graduates as the BSN programs.

If students are not able to enter a program or if they do not complete the program, they obviously cannot enter the workforce.

Another problem with nursing education is the short supply of nurse educators. The California Board of Registered Nursing is predicting the need for 150 more instructors within the next 5 years. This is a reflection of the aging nursing workforce. Nurse educators are retiring. To be a nurse educator in an ADN program the nurse must possess a valid California nursing license, a minimum of one year's experience as a registered nurse providing direct patient care and a master's or higher degree from an accredited college or university which includes course work in nursing, education or administration. Less than 1% of the nursing force possess these credentials. Nurses who enter nursing education may have to keep their service job in order to afford to teach because they must enter on the bottom of the pay scale. Most times they are not given recognition for the required work experience.

Lack of clinical facility space poses another dilemma for nursing programs. Nursing is a practice profession. Students must work with patients in order to master the necessary skills. Currently, most programs must share these clinical facilities with other nursing schools. One hospital may have students at different levels of nursing from 4 or 5 different nursing schools at any time. If a clinical rotation consists of 10 to 12 students per rotation then that becomes a very heavy burden for the hospital and its staff. Imagine a registered nurse with the responsibility for 12 or more patients also interacting with students from two different schools at one time. For instance the staff nurse may be working with students from school "A" at a fundamentals level in an ADN program and school "B" at an advanced medical-surgical level in a BSN program. This is a very stressful situation. If they are not pleasant and friendly, the students may become discouraged and leave the program or choose not to work at that particular institution after graduation. This is a problem for the institution since it will be trying to recruit these people. Even if nursing programs expand, it becomes a real issue about where to place students for clinical experience.

Based on statewide statistics, the California Board of Registered Nursing (BRN 2000) has determined that California will need an additional 25,000 RNs by 2005 and 43,000 by 2010, just to keep a stable ratio of RNs to population. California currently ranks last of all 50 states with a ratio of approximately 554 RNs per 100,000 population (BRN 200). With the need for increased numbers of nurses but with decreasing numbers of qualified nursing candidates, there is no longer a nursing shortage but a nursing crisis. Nurse educators have been looking at this issue for years and trying to determine the direction of nursing education in order to meet the nursing needs for the future.

POSSIBLE SOLUTIONS:

RECRUITMENT:

It is imperative that students be attracted to the nursing profession. With all of the different careers available to students, this is a major challenge. In the past, nursing has been a female-dominated profession. Now there are a myriad of career opportunities with which nursing must compete in order to get qualified nurse candidates. Recruitment of nursing students is not the sole responsibility of the nursing school, it is the responsibility of all nurses. Representatives from the nursing schools should be at every career fair from elementary school on up. Contact needs to be made with elementary school and middle school children to get them thinking about nursing as a career. This means talking with boys and girls about the advantages and value of a career in nursing.

Tours of nursing schools and job shadowing in health care institutions need to be promoted. Too often the only image of nursing that children see is what is in the mass media. Nurses typically are not portrayed as being autonomous, educated individuals who have a tremendous amount of responsibility. They are often portrayed as sexually promiscuous females whose main goal is to have a relationship with a doctor and whose only duty is to follow his/her (usually his) orders and to do nothing else. Until children see what it is that nurses really do, then they will not be encouraged to become nurses. A recent movie "Meet the Parents" has a scene in which the male star states he is a nurse and this is an occasion for the entire family to share a laugh at this man's and the nursing profession's expense. If we want to change the pejorative image of this profession, then it is important to get children out to see real nurses in action.

Nursing schools should assist local high schools and vocational schools with health career academies and creating bridge programs to nursing schools. It is important not to create barriers to students entering nursing school. It is important to improve articulation from the high school into the nursing schools. If you have students thinking about nursing in elementary school, then counseling will be able to guide them to the appropriate courses at the high school and have them articulate smoothly with the nursing school.

Regional Public Service Announcements showing a variety of nursing roles and career choices should be developed and distributed for airing on local radio and TV stations.

Resource kits (of videos, CDs, web sites, and literature) should be developed for school counselors to share with students interested in nursing.

Web sites that create easy access to information on various nursing programs should be developed. Potential students should be able to learn what programs are available in various locations. They should also be able to find the requirements, prerequisites, application procedures and waiting list status from those web sites.

All of these actions will help to attract more students to the profession of nursing.

INCREASING ACCESS TO EDUCATION

Increasing access to education is a key to increasing the nursing population and to improving the education of nurses. Certainly the need for scholarships, grants and other funding is necessary for nursing students. The typical nursing student is married, has children and has a job. Yet this person is expected to spend 17 or more hours per week in lecture and clinical rotations. This does not include time needed to produce research papers, patient care plans and study. Basically, they must give up their lives for these programs. Financial support needs to more than cover tuition. It needs to cover living costs as well!

Work study programs need to be developed. This requires the collaboration of education and service. Work study programs allow students to work with an RN preceptor in the hospital using his/her acquired skills. The student gets paid a living wage and the RN gets paid a stipend in addition to regular pay. The student will receive units for this work. This allows the student to develop skills in his/her profession, get units and maintain any financial aid. The hospital is given the opportunity to recruit and train future staff nurses. It will actually save the hospital orientation costs, which can reach $5,000 per new staff nurse, so this could be a great savings to the hospital.

Obviously, to increase access to nursing programs the nursing programs need more space for classrooms and nursing skills laboratories. Equipment is needed for these rooms. Instructors are needed to teach the additional students. And we need more clinical facilities.

To get the needed space, colleges must look at what is available and can be used. Funding may be required because spaces may need to be built. The government, federal, state and local must look at the budget and provide for the high-cost programs that meet a direct community need. For too long, nursing programs have been told they are too expensive and do not produce enough revenue to justify their existence.

Communities need to be educated about the need for bonds to provide the funds for construction. If the nursing crisis continues on its present course, more units will be closed for lack of nursing staff. Patients will be facing increasing delays in treatment. The population must understand how important growth is to maintain the required nursing population to meet their health care needs.

Monies must be available for new equipment. Health care technology changes about every 3 years. To keep up with this, the nursing skills labs are required to continually have equipment updated. This money can come from federal, state and local governments, from bond issues and from industry.

Alternate modes of instruction need to be more fully utilized. Distance education is appropriate in many nursing theory courses. The technology is available to allow instructors to monitor students performing patient care at distant locations. Interactive video teleconferencing needs to be more fully utilized. This technology is expensive to develop and maintain, but would allow more flexible hours be available for students participating in the programs. Students would be better able to fit school into work and home.

Ways to help students succeed must be found. This may involve remediation, tutoring and other ways to help students acquire the knowledge and skills to be a competent nurse.

Instructors need to be educated and employed. Industry can help subsidize the education of their staff by implementing reasonable programs such as stipends or the 20/40 week in which the employee works 20 hours and gets paid for 40 hours while going to school. The industry needs to share employees. If staff members could be used as clinical instructors, then scheduling needs to be adjusted to allow them to do this.

Within education there needs to be a seamless articulation between ADN to BSN programs and the BSN to MN programs. Ph.D. candidates need to be subsidized. It is a very expensive, long process to obtain this degree, with very little monetary reward. Monies from the federal and state governments should be provided for this.

In terms of clinical space, there must be better ways to utilize space and availability. Presently, many facilities are being used 16-hours-per-day, 7-days-per-week. Some facilities are even being used 24 hours a day. One method to help with this problem would be development of regional web sites, such as the one developed by the Orange County Consortium. The clinical facilities list which units are available in their facility for student use, when they are available and for which level of students. The nursing programs then place the appropriate number and level of students in the available units. No unit goes unfilled and it is a very efficient use of facilities.

It is very important that partnerships between education and industry be rewarded. In order for this nursing crisis to be averted all groups must work together. This should be a win-win relationship.

STEPS TAKEN BY COLLEGE OF THE CANYONS TO RESPOND TO THE NURSING SHORTAGE:

College of the Canyons has taken the nursing shortage very seriously. In July 2000, the College created the Allied Health Division. The Nursing Department is now the major department in this division and not a small department as it was under the Math-Science Division. My position of Assistant Dean of Allied Health was created. This is an administrative position and one of my major responsibilities is to find ways to expand the program and improve student outcomes.

We have opened and equipped a second Nursing/Allied Health Skills Lab. The College committed a second large classroom to be converted to a skills lab. Using new program funds, generous donations from local industries and grant money, the lab was equipped and an older lab was updated.

As previously stated, the application period was extended to a year round basis. Instead of having empty student positions, we now have 119 qualified applicants awaiting entry into the program.

The College has a general obligation bond measure on the November ballot for $82.1 million. If approved by voters, monies from this bond will support the construction and equipping of another new large nursing lab.

The College is pursuing the possibility of obtaining industry support for another nursing instructor position. The administration is committed to supporting the position if industry pays the first 2 years. If sufficient funding is obtained from the State, the College has stated that the nursing position will be in the top 10 positions that are approved for hire.

The College has an Institutional Research Department that has, as one of its goals, the responsibility to pursue alternative funding sources to support programs to maintain the highest quality of instruction and equipment. To this end the department lead in the writing of 5 grant proposals for nursing alone, which resulted in over $32,000 of funding. In addition, the College of the Canyons Foundation has also pursued funding sources in industry.

An articulation agreement was signed with 2 local high schools, Valencia High School and Canyon High School which would allow students who took their honors anatomy and physiology courses to count those as meeting the anatomy and physiology requirements of the nursing program. The molecular biology course offered on these campuses will meet the prerequisite for the College of the Canyons anatomy and physiology courses.

Articulation agreements are presently being negotiated with California State University Northridge. Presently we have reached agreement on dual enrollment in the two programs and early enrollment in the CSUN program. This means if a student attends school full time, he/she would have ADN in two years and a BSN in 2 more years. We are currently negotiating use of clinical courses for upper division units. We have already been working with CSUN in allowing them to use our video teleconferencing center for some of their courses. We are negotiating to bring their BSN program to our new University Center.

The position of Gender Equity Tutor has been created and funded with Vocational Applied Technology Education Act (VATEA) monies. This is a male student who assists in the nursing skills lab. He assists students when they practice various techniques and tutors them in math and in nursing courses. As a male, he is a role model and will present nursing as a profession for males in a positive light. Through his efforts, College of the Canyons nursing programs have a very low attrition rate, approximately 5%.

A new course, Medical Terminology for students for whom English is not the primary language, was just developed and will be offered in the spring. Again, this course was developed to enable students to progress through the nursing program with greater ease.

Arrangements have been made with the middle schools to bring their students to the nursing skills labs for regular tours. Money has been made available to provide promotional items to keep nursing present in these children's minds.

As Assistant Dean of Allied Health, I have participated in numerous career fairs. The Radio and TV department created a video for us that I take with me and show to these groups on a regular basis.

CLOSING THOUGHTS ON THE NURSING CRISIS

My primary concerns are to enhance the image of nursing and obtain needed funds. The image of nursing must be improved. This is a responsibility of every nurse in the community. We must look at our appearance, our behavior and what it is we are communicating. But it is incredibly difficulty to project a positive image after working four twelve-hours shifts in a row or having mandatory on-call or overload. It is hard to be positive when required to take care of two or three times the appropriate patient load. It is hard to be positive when you consider the nurse's responsibility in relation to compensation received The health care industry must make an effort to provide stronger incentives to the nurses that are currently working so they, in turn, are more positive about their chosen career. The mass media must assume responsibility for projecting a more positive and more accurate image of nursing.

Education must ease access to programs but at the same time maintain quality. This is difficult but not impossible. As nurses, we have been doing the impossible for a long time so we should be able to meet the challenges, but we need financial assistance. As with any profession, it costs money to educate the members. Funds need to be provided for growth. California has recognized the need for nurses by setting aside $5 million for associate degree nursing programs, even while cutting the community college budget. The Government must recognize the need for total quality management – quality products that are created faster, cheaper and better.

Associate degree nursing programs produce high quality nursing professionals. Associate degree nursing programs represent an accessible avenue to an affordable and high quality education for many individuals who would not otherwise be able to pursue the career of nursing. These programs are the most cost effective to the taxpayer. The Associate degree programs increasingly reflect the diverse demographic composition of the nation. The ADN graduates have reliably and consistently demonstrated competence and excellence in the workplace. Multiple pathways to registered nursing education and entry level employment are essential in order to meet the varied needs and goals of students interested in a nursing career. At this time, we are looking at the very real possibility of further terrorist attacks and the possibility of war. We have no concept of the number of casualties resulting from these. We are already in a nursing crisis. We need nurses and we need them now, not in 4 years. It is an absolute necessity that all nurses and all levels of government work together for solutions to the nursing crisis. This is a burden that must be borne by all branches of government and by the community. I know my college has definitely committed to helping in this crisis, but it cannot meet the nursing needs of the community alone. In this time of crisis, it is important that all resources be pooled and used effectively.

APPENDIX H - WRITTEN STATEMENT OF CAROLYN McCULLOUGH, MA, RN, NATIONAL COORDINATOR, NURSE ALLIANCE, SERVICE EMPLOYEES INTERNATIONAL UNION, WASHINGTON, D.C.

Testimony of Carolyn McCullough, MA, RN

Before the Committee on Education and the Workforce

September 25, 2001

Thank you, Chairman Boehner and Congressman Miller, for allowing me to testify at this hearing on behalf of the Service Employees International Union on the current nursing crisis in this country.

My name is Carolyn McCullough. I am a registered nurse (RN), and the National Coordinator for SEIU's Nurse Alliance. Today I am speaking on behalf of the 1.4 million members of SEIU, more than 710,000 of who work in the health care industry, more than 110,000 of whom are nurses, and more than 120,000 of whom work in nursing homes.

As we all know, this hearing was changed because of the devastating attacks on Sept. 11. Nothing will ever be the same again. As evidenced by these tragic events, thousands of people needed medical care, and nurses were on the frontlines delivering this care. Like any essential emergency personnel, nurses are always ready to provide whatever care is needed in times of crisis, without being asked and without concern about time or being paid. This is what happened on Sept. 11th in New York, Washington, and Pennsylvania. But a crisis like this highlights the essential need to have adequate numbers of nurses available. For this reason, addressing the current nursing crisis and the impending shortage is imperative.

As the largest and fastest-growing union of nurses in the country, SEIU is committed to achieving access to quality health care for all who live and work in America—and quality jobs for all who dedicate their lives to caring for others. In May 2001, our Nurse Alliance released *The Shortage of Care*, a report that is helping to redefine the nation's nursing shortage. This report on the nursing crisis is based on the views of nurses in acute care facilities collected as part of a nationwide survey conducted by an independent polling firm.

Conventional wisdom about the shortage has held that it's a recent crisis driven by demographic shifts in a traditionally female profession. But the fact is that this is the second nurse shortage I have experienced in my career, and it is also the third shortage for many nurses in this room. The roots of this crisis go much deeper than the changing roles and attitudes of women in our society.

With the rise of managed care in the 1980s, long before a nursing shortage began to emerge, hospital administrators moved to cut costs by cutting staff, particularly by laying off huge numbers of registered nurses. Across the country, the industry reduced staffing levels to the point where nurses—increasingly unable to provide our patients with the care we were trained to give—began to leave hospitals for more rewarding and less physically and emotionally taxing jobs.

Nurses in hospitals and related facilities are caring for more patients today than we did a decade ago. And because of restrictions on hospital admissions and lengths of stay imposed by managed care, the patients in hospitals are more acutely ill and in need of greater care.

The result is that hospitals are having increasing difficulties filling vacancies for RNs. This is confirmed by our survey, where:

> nurses reported that on average it took nearly 11 weeks (10.77) to fill a nursing vacancy in their unit, and
>
> 52 percent of the nurses believed that it takes longer to fill vacancies today than three years ago.

This doesn't just show nurses' job dissatisfaction; it signals a real problem for patients. When staff is less experienced and unstable, it is more likely that patient care will suffer.

The hospital industry cites many of these statistics to point to a nationwide "nursing shortage." But a closer look at the data suggests that the real problem is *a shortage of nurses willing to work in hospitals under current working conditions*. This opinion was also shared by the General Accounting Office in their recent report, "Nursing Workforce: Emerging Nurse Shortages Due To Multiple Factors." We view the situation as a *staffing crisis* rather than a nursing shortage; systemic understaffing brought on by the restructuring of the industry under managed care has led to dramatically deteriorating working conditions and increasing concern about the quality of patient care which is causing nurses to leave hospitals. This is confirmed in a survey of health care human resource managers conducted by the William M. Mercer consulting company who found three important factors affecting turnover:

> "dissatisfaction with the job itself, working conditions, the relationship with the supervisor, or career opportunities;"
>
> "workload and staffing," noting that "a reduction in RN resources has increased the job demands of those remaining in the workforce."
>
> "better pay."

They warn that employers concerned about turnover "should examine their own practices and work environment..."

It cannot be stressed enough that when our nursing profession is in crisis, our nation's health care system is in crisis.

Inadequate staffing has given rise to increased numbers of medical errors. In 1999, the Institute of Medicine found that between 44,000 and 98,000 Americans die every year in hospitals due to medical errors; more people die of medical errors than from motor vehicle accidents, breast cancer, or AIDS. While the IOM report exposed a national crisis, it did not explore one of the primary causes of it: understaffing. However this issue was comprehensively assessed by a research team from the Harvard School of Public Health led by Professor Jack Needleman, which found that higher RN staffing was associated with a 3 to 12 percent reduction in the rates of patient outcomes sensitive to nursing—in particular urinary track infections, pneumonia, length of stay, upper gastrointestinal bleeding, and shock.

A majority of nurses in our SEIU survey identified understaffing as the cause of medical errors. And the situation, they say, is not improving.

> 54 percent of nurses say that half or more of the errors they report are the direct result of inadequate staffing.
>
> Despite the growing attention focused on medical errors, most nurses say the rate of incidents has remained unchanged over the last year—while fully 30 percent of nurses say the errors have actually increased.

We also should keep in mind that there are many more medical errors that go unreported for fear of retaliation. Most health care workers who blow the whistle on short staffing and poor patient care have no legal protections against retaliation. Federal whistleblower laws are narrow in coverage and do not apply specifically to the health care industry. That is why we are fighting so hard for a Patients' Bill of Rights that includes whistleblower protection.

In the state of Maryland, the staffing crisis and the deteriorating conditions it has created have compromised quality care for people in our communities. According to the Maryland Hospital Association, "over half the hospitals throughout Maryland report they have had to close beds, delay and cancel surgeries, disrupt scheduled procedures, and 'reroute' ambulances to other facilities for emergency patient care." The MHA says that it is increasingly common for patients arriving in an emergency department "to be held there until adequate staffing becomes available on a patient unit."

In Baltimore, Johns Hopkins Hospital has closed as many as 10 of the 44 beds in its neurology and neurosciences center, because it doesn't have the nurses to safely staff them. Heidi Zhang, a nurse at Hopkins for 13 years says that "People have come in for elective surgeries and been sent home. I've never seen anything like this."

A particularly devastating side effect of the understaffing crisis is the abuse of mandatory overtime by many health care employers. Nurses are often mandated to work back-to-back eight-hour shifts or four extra hours on top of a 12-hour shift to fill gaps in staffing. Of course this threatens patient safety. There is no way an exhausted, overworked nurse is as alert and accurate as a well-rested nurse working a regular shift. Mandatory overtime also places an incredible stress on family life, particularly when last-minute changes have to be made to find child care or care for elderly parents.

Mary Hesse-McBride is a nurse and an SEIU member who used to work in the cardiac intensive care unit at the University Hospital in Madison, Wisconsin. Too many overtime hours drove her out of intensive care—where the nursing shortage is particularly acute—to the outpatient unit. She would often say "I would go to work and I would never know if I was leaving."

Mary Hesse-McBride is not alone. According to our survey, nurses in acute care hospitals work an additional 8.5 weeks of overtime on average every year. Nurses are increasingly required to work excessive amounts of mandatory overtime. They are also required to "float" or be reassigned to units where they lack the experience and training. Nurses are being stretched to the limit, experiencing high levels of stress, chronic fatigue, and work-related injuries. These intolerable work practices lead to further "burnout" and undermine nurses' sense of professionalism. Combined, these conditions are driving nurses from hospitals.

According to the SEIU survey:

> Only 55 percent of acute care nurses plan to stay in hospitals until they retire.
>
> And only 43 percent of nurses under 35 plan to stay in hospitals until retirement.
>
> But 68 percent of nurses say they would be more likely to stay in acute care if staffing levels in their facilities were adequate.

These statistics show a little-discussed fact about today's "shortage." In reality, the current supply of nurses far exceeds demand. According to a recent Health Resource Services Administration (HRSA) report, there are approximately 500,000 nurses who have licenses but are not practicing in the nursing field. The proportion of RNs employed in hospitals has decreased substantially and consistently from 68 percent in 1988 to 59 percent in 2000.

Deteriorating staffing and working conditions have led many nurses to leave the profession altogether, and fewer young people are entering it: nursing school enrollment has declined in each of the last six years. As a result, the average age of working RNs has increased 7.8 years since 1983 to 45.2. And as these trends continue, there is likely to be a severe nursing shortage in the future. By 2020, we expect that there will be a shortage of 400,000 nurses, when the majority of the baby boomers will be seeking care.

Nurses wish to remain in hospital work, and would do so if staffing and working conditions improve. If these conditions are not improved, nurses' exodus from hospital care will intensify and in the near future we will face a true shortage. The fact that younger nurses are even less likely to stay in acute care than their older colleagues is a warning sign.

The study by the SEIU Nurse Alliance, *The Shortage of Care*, is filled with compelling stories by nurses about the tolls of short-staffing. These stories echo those of colleagues nationwide. A Washington State nurse gave the following reason as to why she was leaving hospital nursing:

> I have been a nurse for six years and for most of that time I have worked in the hospital environment. It is difficult to tell you how terrible it is to "work scared" all the.time. A mistake that I might make could easily cost someone their life and ruin mine. Every night at work we routinely "race the clock." All of us do without lunch and breaks and work overtime, often without pay, to ensure continuity of care for our patients. Yet, we are constantly asked to do more. It has become the norm for us to have patient assignments two and a half times greater then the staffing guidelines established by the hospital itself. I cannot continue to participate in this unsafe and irresponsible practice. So I am leaving not because I don't love being a nurse, but because hospitals are not safe places: not for patients and not for nurses.

I have focused my remarks principally on hospitals, since that is where the nurse crisis is most severe. There is, however, a related and equally serious problem in nursing homes. While RNs make up a small proportion of the nursing home workforce, and are largely in managerial positions, most of the staff in nursing homes are certified nurse assistants (CNAs) and, to a lesser extent, licensed practical nurses (LPNs) or licensed vocational nurses (LVNs).

SEIU members include more than 120,000 nursing home employees, the vast majority of whom are CNAs and a large number of whom are LPNs/LVNs. Similar to administrators in the hospital industry, nursing home owners have argued that they are facing a shortage of nurses and nurse aides. For this reason they have asked for increased Medicare and Medicaid reimbursement and have resisted the setting of minimum staffing standards.

But just like in hospitals, the real problem isn't finding people to work in nursing homes. It is keeping them there. Turnover rates for direct care workers in nursing homes are nearly 100 percent, creating a revolving door of caregivers. This renders impossible the continuity of care, which remains a crucial factor in patient morale and patient health. Workers are leaving due to heavy workloads: They simply do not have enough time to care for the number of residents they are assigned to, which leads to stress, guilt, and burnout. Moreover, low wages, lack of health insurance coverage, and high injury rates also make nursing home work unsustainable for many workers.

Just like nurses, more and more people who have become certified to work as nurse aides are leaving the profession. For example, the state of Iowa reported last year that there were between 50 and 60 thousand names on the CNA registry but only 23 to 24 thousand were actively working in nursing homes.

Now that we have outlined the crisis that exists in our hospitals and nursing homes, we can discuss what is being done to change these conditions and what can Congress do to stop the nursing profession from bleeding to death.

Nurses across America are sounding the alarm: staffing levels are too low to provide the quality of care their patients need. In many states, nurses who are in unions have turned to the bargaining table to change their working conditions in order to ensure safer staffing and better patient care. Eliminating mandatory overtime, establishing safe staffing standards, and improving recruitment and retention by increasing pay have been the primary issues in nurse contract negotiations from coast to coast. One has only to look at the number of strikes occurring among nurses in 1999 (21) and 2000 (10), and those so far in 2001 (7) to see that nurses are increasingly determined to resolve the problems they face in hospitals today.

I am proud to report that many members of SEIU's Nurse Alliance have been able to negotiate limits—if not outright prohibitions—on mandatory overtime. In the Dimension's Health Care contract, our union has ensured that our hospital's past practice of not requiring mandatory overtime is followed. And I can tell you that it is an incentive for many nurses to stay on at that hospital. Earlier this year, SEIU nurses at Aliquippa Community Hospital in Pennsylvania became the first in their state to win an agreement in their contract eliminating mandatory overtime. Their hospital CEO, Fred Hyde, recently joined nurses in pressing for a state law in Pennsylvania to protect patients and nurses from mandatory overtime, calling it "involuntary servitude."

SEIU nurses at Kaiser Permanente, the League of Voluntary Hospitals in New York, Swedish Medical Center in Washington state, and many other hospitals have negotiated contracts with breakthrough agreements that give bedside nurses a voice in setting staffing levels through labor-management committees. But while we have made some progress, this issue is too big and too important to the health of our patients, our profession, our hospitals, and our communities to address hospital by hospital and contract by contract.

In addition, while collective bargaining is the only venue that nurses can currently use to protect themselves against unfair and abusive working conditions, such as mandatory overtime, that jeopardize quality patient care, their right to collectively bargain is constantly under threat. Two recent Supreme Court decisions: *NLRB v. Health Care & Retirement Corp. of America* and *NLRB v. Kentucky River Community Care Inc.*, have eroded nurses' rights to act collectively under the protection of the National Labor Relations Act. As these challenges to nurses' ability to address workplace and quality patient care issues through collective bargaining mount, it becomes more imperative that policy-makers act now to ensure decent working conditions for our country's nurses and thereby ensure safe patient care and a adequate nurse workforce for the future.

SEIU along with other unions and the American Nurses Association have introduced legislation on the state level to establish safe staffing standards, ban mandatory overtime, provide whistleblower protection for nurses when they speak out on understaffing that jeopardizes good patient care, and provide for involvement of direct care nurses in the development of staffing policies.

California was the first state in 1999 to pass legislation to require fixed minimum staff-to-patient ratios in hospitals. The regulation that will spell out the specific statewide standards is expected to take effect next year. In an action of historic proportions, Kaiser Permanente has recently become the first employer to endorse the ratio proposal put forth by the SEIU California Nurse Alliance. There is also safe staffing legislation being considered in New Jersey, New York, Oregon, and Pennsylvania. Legislation was introduced in Illinois with the support of the SEIU Nurse Alliance and the Campaign for Better Health Care. The model bill calls for hospitals and other facilities to: meet minimum staffing requirements set by the legislature, submit annual staffing plans that include a system for determining staffing levels based on acuity (severity of illness or injury), maintain daily staffing records, prohibit mandatory overtime, set maximum hours for nurses, protect whistleblowers, publicly disclose mandated and actual staffing levels, and provide access to unannounced inspections.

Other states are also considering laws prohibiting or restricting mandatory overtime for nurses. Maine and Oregon have just passed legislation banning mandatory overtime. Mandatory overtime legislation has been introduced in Maryland, New Jersey, New York, Rhode Island, Washington, and West Virginia, and may soon be introduced in Connecticut, Massachusetts, Pennsylvania, and Wisconsin. In West Virginia, the SEIU Nurse Alliance successfully introduced legislation that would provide whistleblower protection for nurses who report staffing problems. Similar legislation has passed in the state of Washington.

On the federal level, legislation has been introduced designed to attract new people into the nursing profession by making it easier to access educational and training resources. While we applaud these efforts, this will not address the fundamental problems facing our profession and our patients. America's hospitals are in a state of emergency. And it's one that will only grow worse as the nursing shortage grows more severe. Forcing more mandatory overtime or simply relying on new nurse recruitment programs won't solve the problem either. Likewise, easing immigration rules to attract more foreign nurses or expanding the number of visas allowed for nurses and nursing home workers will only push more caregivers through the revolving doors of our nation's hospitals and nursing homes. All of these measures will only treat the symptoms, not cure the disease. Unless and until we address the understaffing and poor working and patient care conditions that plague nurses, we will never solve the shortage.

We also need staffing standards that will change the culture of care in nursing homes to one of which ends the assembly line and instead truly values residents and their lives. And we need adequate reimbursement with built-in accountability to ensure that taxpayer dollars are spent on resident care instead of profits. We support many of the recommendations proposed by the National Citizens Coalition for Nursing Home Reform.

Fundamentally, the solution to the nursing crisis lies in the establishment of safe staffing standards in our hospitals.

> We must set enforceable minimum staffing standards linked to the acuity of patients, skill of the staff, and skill mix to ensure good quality care in hospitals, emergency rooms and outpatient facilities. But we must make sure that such minimums do not become the maximums.
>
> We must make safe staffing a requirement for all hospitals receiving federal taxpayer dollars.
>
> We must make sure the federal government provides adequate oversight of our hospitals, and that the industry's self-monitoring system under the Joint Commission on the Accreditation of Healthcare Organizations be reformed.
>
> And we must protect the rights of patients and the rights of health care workers who blow the whistle on staffing problems that jeopardize the quality of care.

To be sure, it will take time to enact and implement staffing standards. The understaffing problem didn't develop overnight, and neither will the solution.

We must find ways to set meaningful standards for staffing in the health care industry. Understaffing in our nation's hospitals is a serious problem. It's a problem that will only be solved through the joint efforts of public officials, nurses, and hospital administrators. And it's a problem that must be solved if we are to guarantee quality care for patients – and keep skilled nurses in our hospitals.

Additionally, on the education front SEIU would encourage this committee to explore support for the establishment of public-private partnerships that would provide educational programs, including money for tuition, that establish career ladders for nursing assistants to become licensed practical nurses and for licensed practical nurses to become registered nurses. There are tens of thousands of dedicated health care workers in our country's hospitals, nursing homes and in home care, who leave healthcare employment because of intolerable working conditions and poor pay and benefits. They could be a valuable resource to address our future shortage needs. SEIU is currently working on developing such a program jointly with a number of employers. One of the major objectives is that this program should be worker friendly and we hope to accomplish that through the use of on-line distance learning and a clinical component based in the workplace. Another objective of the program is to establish a prior learning assessment tool that credits the student for prior learning and experience. This would enable them to complete the course work in as expeditious a manner as possible and move them into the workplace where their services are so desperately needed. Obviously these programs would have to be fully credentialed, and the providers must be reputable institutions of higher education. We feel these types of programs should be supported nationally and we would be happy to assist the committee in any way possible.

But there is a step we can take today, immediately, to stop the hemorrhaging—and that's to put a ban on mandatory overtime. SEIU, along with other unions representing health care workers, are working with Representative Stark to introduce legislation that would ban mandatory overtime. At the SEIU Nurse Alliance Stand for Patients rally on the Capitol steps last May, nurses from around the country talked about the harmful side-effects of mandatory overtime on their patients, themselves, and their families. One nurse said she could not pick up her home phone on a rare day off for fear of being called back into work for another extended shift. Limiting forced overtime will ease the impact of the shrinking supply of nurses by encouraging more nurses to stay in the profession. And it will protect countless patients in the same way that limits on mandatory overtime for train engineers, air traffic controllers, truck drivers, and other occupations where public safety is at risk.

Thirty years ago I became a nurse because I wanted to make a difference. Caring for people when they are ill and at their most vulnerable, especially those so often under served, really appealed to me. I thought I could help them get better and stay healthy, and what I found out is that I really could. I have spent many years as a nurse and along the way I learned that nurses are the critical link between people and health care, and without nurses there is no health care.

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APPENDIX I - WRITTEN STATEMENT OF DR. JEAN BARTELS, CHAIR, SCHOOL OF NURSING, GEORGIA SOUTHERN UNIVERSITY, STATESBORO, GA

Testimony of Jean Bartels, PhD, RN

Before the Committee on Education and the Workforce

September 25, 2001

Good afternoon, Mr. Chairman and Members of the Committee. Thank you for inviting me to speak to you today on educating the future nursing workforce. I am Jean Bartels, PhD, RN, Chair of the School of Nursing at Georgia Southern University in Statesboro, Georgia. I am here presenting the views of the American Association of Colleges of Nursing (AACN) which represents 556 baccalaureate and graduate schools of nursing across the United States. I am heartened that the Congress is investigating the nationwide shortage of nurses available to care for our citizens. I am hopeful that Congress will invest in our health care education infrastructure, part of which is the 2.7 million nurses that make up the backbone of the health care workforce.

The Current Nursing Workforce

Registered nurses (RN) are the nation's largest group of health care professionals that provide up to 98% of all patient care in hospitals and other settings. With more than four times as many RNs in the United States as physicians, nurses comprise the largest single component of hospital staff and deliver most of the nation's long-term care. Most health care services require some form of nursing care. Of the nation's 2.7 million registered nurses, 2.2 million or 81.7% report being employed in nursing. The average age of the RN is 43; 12.3% come from racial/ethnic backgrounds; only 5.4% are men.

Approximately 60% of all RNs are employed in hospitals. This percentage has declined in recent years as health care has moved beyond the hospital into a wide range of settings. In addition to hospitals, today's nurse practices in health maintenance organizations, public health agencies, primary care clinics, private practices, home health care, nursing homes, outpatient surgicenters, nurse-managed health centers, insurance and managed care companies, schools, mental health agencies, hospices, the military, and private industry.

Nurses practice in collaboration with physicians and health professionals from other disciplines. The role of the professional nurse ranges from direct patient care and case management to establishing nursing practice standards, developing quality assurance procedures, and directing complex nursing care systems. The average salary for an RN who was employed full-time in 2000 was $46,782.

According to the first *National Sample Survey of Registered Nurses* prepared in

1980 by the Division of Nursing (DoN) within the Department of Health and Human Services, almost 63% of RNs held a hospital diploma as their highest educational credential, 17.3% a bachelor's degree, and 19% an associate degree. According to the most recent survey data released for the year 2000, a diploma was the highest educational credential for only 29.6% of RNs, while the number with bachelor's degrees has climbed to 29.3%, and the number of associate degrees to 40.3%.

The Emerging Nursing Shortage

The United States is in the midst of a nursing shortage that is projected to intensify as baby boomers age and the need for health care grows. Compounding the problem is the fact that the pipeline of new nurses is shrinking and a significant part of the current nursing workforce is planning to leave the profession.

In February 2001, the DoN reported that the nursing workforce in the United States increased 5% in size since 1996—the smallest increase reported in the 20 years in which this data has been collected. As the number of RNs is leveling off, the demand for nurses is increasing. The U.S. Bureau of Labor Statistics projects that the number of RNs needed to deliver care will grow by almost 22% by 2008, with a projected need of 794,000 new RNs. This growth rate is faster than the average of all other occupations.

The Government Accounting Office reported in July 2001 that "a serious shortage of nurses is expected in the future as demographic pressures influence both supply and demand." Other federal projections indicate that by 2010, the demand for RNs will begin to outstrip the anticipated supply, and that by 2020, demand will grow nearly twice as fast as the expected increase in the RN workforce. By the year 2020 the nation's health care system will experience a 20% shortage in the number of nurses needed—a shortage of more than 400,000 RNs nationwide, according to a June 2001 *Journal of the American Medical Association* report by Peter Buerhaus, Phd, RN, FAAN. Although health care continues to shift beyond the hospital to more community-based primary care and other outpatient sites, federal projections say the rising complexity of acute care will see demand for RNs in hospitals climb by 36% by 2020.

Projections aside, our nation's hospitals need 126,000 nurses now, according to data published in June 2001 by the American Hospital Association. Of all hospital vacancies today, 75% are for nurses.

A factor contributing to the slow growth in the nursing workforce is the decline in nursing schools enrollments over the past six years. According to annual data collected by the American Association of Colleges of Nursing (AACN), enrollments in entry-level baccalaureate nursing programs are down 21% since 1995.

The number of students taking the national licensure examination to become RNs is also decreasing. The National Council of State Boards of Nursing reports the number of first-time, U.S. educated nursing school graduates who sat for the NCLEX-RN® (National Council Licensing Examination for Registered Nurses) decreased by 26% between 1995 and 2000. A total of 25,046 fewer students in this category of test takers sat for the exam in 2000 as compared with 1995.

Data also show a dramatic increase in nurses exiting the profession. Although half of the nation's RNs will reach or near retirement age within the next 15 years, one out of every five practicing nurses is considering leaving the patient care field for reasons other than retirement within the next five years according to an April 2001 report from the Federation of Nurses and Health Professionals. An alarming report published in May 2001 by Linda Aiken, PhD, RN, FAAN, FRCN indicates that more than 40% of nurses working in hospitals are dissatisfied with their jobs, and one out of every three hospital nurses under the age of 30 is planning to leave her or his current job in the next year.

The Georgia Experience: Georgia's nursing shortage reflects what is happening nationwide. In June 2001 the Governor's Health Care Workforce Technical Advisory Committee reported that with a deficit of more than 2,000 RNs in hospitals and nursing homes alone, Georgia risks potentially catastrophic shortages in the near future if it does not act quickly to address the shortage. In addition, the data show that vacancy rates for nurses in Georgia is 13% in hospitals, 15.4% in nursing homes, and 17.4% in public health departments. While Georgia's demand for nurses this year is 52,000, its projected supply of nurses is only 50,000. Equally troubling, this deficit is expected to continue to grow rapidly as Georgia's population and nursing workforce ages. The growth in Georgia's elder population is up 49.6% for ages 50-59, 9.4% for ages 60-69, 17.4% for ages 70-79, and 34.2% for age 80 and above. Comparably, the age distribution of nurses is rising. Only 25% of Georgia's nurses are aged 30-39, while 35% are aged 40-49, 20% are 50-59, and 10% are over 60 years of age. If this pattern continues, by 2020 the supply of RNs is predicted at best to be 60,000 with a demand of 72,000 nurses.

The number of new licenses awarded to RNs in Georgia is declining dramatically, as are enrollments in undergraduate nursing programs. Georgia is in the bottom 10% of states in the number of RNs per capita (712.5 nurses per 100,000 population compared to U.S. average of 797.7 nurses per 100,000). Consequently, Georgia ranks 40th of the 50 states in terms of nursing workforce supply. Similarly, there are 20.7 per 100,000 Advanced Nurse Practitioners in Georgia compared with the U.S. average of 26.3 per 100,000. Georgia ranks 34th of the 50 states in the delivery of advanced practice nursing care.

In fiscal year 2000, 1,000 fewer nurses received RN licenses in Georgia than in 1996, which is directly tied to declines in student enrollment. The University System of Georgia reports that enrollments in nursing programs have dropped significantly since 1993—8,000 in 2001 compared to 23,000 in 1993. Much of this drop in enrollment is attributed to a decrease in associate degree program candidates as individuals realize the necessity for a Bachelor of Science in Nursing (BSN) in today's health care system coupled with the increases in time required for associate degree completion, program credits required for an associate degree, and expenses associated with attending an associate degree program. The number of graduations from all nursing programs in Georgia has decreased from 1,671 in 1991 to 1,358 in 2000.

Nursing Education Today

Today there are approximately 1,666 schools of nursing educating more than half (52%) of all health profession students in the United States. Of that total, 695 are educating students at the baccalaureate and graduate level. For the sixth consecutive year, enrollments in entry-level baccalaureate programs in nursing have declined according to AACN data. Since 1995 enrollees have declined 21.1%; graduates have declined 16.5%. On the average over the six-year period, the number of enrollees and graduates have declined by 3,151 and 812 each year, respectively.

Nursing educators look with trepidation at the six years of declining enrollments in baccalaureate nursing programs and express doubts about the potential to turn that around. Students express feelings of confusion that the professionals they seek to join encourage them to change their majors expressing the view that to choose a nursing career is a colossal mistake.

To make matters worse, the current nursing shortage is creating calls to produce more nurses from all entry-level programs with no focus on the varying competencies of nurses from different educational programs. This short-term fix to bolster the number of entry-level RNs fails to recognize its effects on efforts to recruit baccalaureate-level students into nursing or the long-term impact on the profession.

During a time of shortage of health care professionals, there is a predictable trend to deregulate and substitute lesser-prepared persons. During previous nursing shortages, Boards of Nursing have been pressured to reduce the requirements for entry into the profession by decreasing the passing standard of the licensing examination and/or waiving requirements for licensure. Other regulatory entities have been pressured to lower agency staffing standards, for instance by allowing unlicensed technicians to function in the emergency room without RN supervision or by substituting unlicensed personnel for licensed nurses.

Lowering educational standards is an inappropriate and potentially dangerous response to a shortage of health care professionals. This short-term response will not help to define the professional practice of nursing, will interfere with the delivery of quality patient care, and is inconsistent with the long-term vision of what nursing needs to look like.

Faculty Shortages Contribute to the Nursing Shortage

Faculty shortages at nursing schools across the country are contributing to the overall decline in new enrollments. Data from AACN's *2000-2001 Enrollments and Graduations in Baccalaureate and Graduate Programs in Nursing* show nursing schools turned away 4,967 qualified students across the United States due to insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints. More than a third (38.8%) of the schools surveyed pointed to faculty shortages as a reason for not accepting all qualified applicants into entry-level baccalaureate programs. In October 2000, AACN reported 336 vacancies from 209 responses to a survey of 553 graduate schools of nursing. Sixty-four percent of these vacancies were for individuals with the doctoral degree.

The same factors that are affecting the nation's supply of practicing nurses are impacting the supply of nurse educators. Nursing faculty are aging with nearly half (49.4%) of new doctoral graduates being age 45-54; 6.5% are age 55 and older. With the average age of full-time nursing faculty now 49, a wave of retirements is expected to peak in just ten years. The pipeline of students planning to become educators is inadequate to replace retiring nursing faculty with less than 1% of baccalaureate nursing students indicating a desire to teach after graduation. Efforts to recruit students into nursing programs must be complimented by initiatives to prepare faculty and infrastructures to educate them.

Universities, which generally pay less than private sector employers, must compete with expanded opportunities that offer more lucrative benefits, less stressful work environments, and 9-to-5 workdays to attract and keep nurses in teaching roles. Many educators say faculty life presents a harder road than private practice or administration. For clinical faculty in particular, hours are long and working conditions increasingly arduous. RN staffing constraints and sicker patients have driven many hospitals to limit or lower the number of nursing students they will accommodate for clinical training. This reality forces faculty to scatter their charges more thinly over several floors while still trying to provide adequate instruction and supervision, as well as take responsibility for the students' assigned patients.

In 1998, 411 people graduated from doctoral programs in nursing, according to AACN data. Of those, only 43% had an employment commitment to serve as nursing school faculty. Another 17% had accepted non-academic positions. Compounding the problem is the fact that once nurses begin working full-time, it is very difficult to bring them back to study full-time for a doctoral degree. The majority of baccalaureate graduates enter the workforce after an undergraduate program due to financial need. The percentage of master's nursing students pursuing academic careers is also on a steep decline, dropping 27.5% from 1997 to 1998 alone.

Colleges and universities are caught up in a vicious cycle: lower enrollment equals less revenue equals less faculty. Indeed, several schools report they have reduced faculty numbers because of lower enrollments. Educators warn that while applicant numbers inevitably will increase as word of the growing demand for nurses spreads, enough educators simply will not be there to train the nursing workforce on which the nation depends.

Georgia's Faculty Shortage: To complicate the situation, serious shortages of nursing faculty are causing Georgia schools to reduce or limit the number of students admitted to nursing education programs. In Georgia, the average nursing faculty age is just over 51 with 39% of current nurse educators planning to retire by 2005. If these retirees are not replaced, only 149 faculty will be left to cover 27 nursing programs representing an average of 5.5 faculty per program. Of note, only four master's students graduating in 1998 from the Georgia University pipeline indicated an interest in an academic career. A major reason cited for this lack of interest is the fact that salaries for nursing faculty in Georgia are not competitive with other states or with the practice environment.

Educational Preparation and Necessary Skills for the Practicing RN

The nursing profession has struggled for decades with concerns about educational preparation and skill levels necessary for providing safe and appropriate nursing care. Educators agree that nursing practice requires a strong background in the basic sciences—biology, anatomy, chemistry, pharmacology, pathophysiology. These basic sciences lay the foundation for the assessment skills that allow for the formulation of plans of care by nurses at the bedside. With patients in hospitals, long-term care settings, and the home care arena having complex multi-system illnesses, nurses must provide a critical level of assessment skills, employ highly complex forms of health interventions, and use advanced technology. Sadly, the moments available to provide gentle and personal care have been replaced more often than not by technical tasks including monitoring blood gases, weening patients from cardiac bypass pumps, and caring for a fragile, ventilated patient at home.

By necessity nurses are becoming increasingly more knowledgeable in the assessment and treatment of health systems problems. RNs are expanding their skill sets beyond direct patient care to encompass the function and care of health systems. Nurses continue to take on health systems roles in discharge planning, quality assurance, utilization review, systems management, and information systems within different health care settings. Nurses work in research settings on complicated protocols in an effort to advance health science. Nurses bring their patient-centered, high touch approach to these alternative nursing roles. Indeed, nursing practice and care should expand beyond the bedside to allow for the growth of the professional nurse and health care delivery.

Currently, there are three types of nursing programs that prepare students to sit for the licensure exam, or NCLEX-RN®, to become registered nurses. Hospital-based diploma programs offer a three-year education and were established in the 1800's to educate nurses in the care of the hospitalized patient. Begun in the 1950's in the wake of an earlier nursing shortage, associate degree nursing programs offer a two-year curriculum focusing on the technical aspects of nursing care. The four-year baccalaureate nursing programs were established at the turn of the century to prepare nurse leaders to practice in hospitals and public health systems.

The changing characteristics of the health care delivery system are resulting in dramatic changes in the nature of education and may also require a reexamination of the education required for nursing practice. AACN along with other leading nursing organizations recognizes the Bachelor of Science degree in Nursing (BSN) as the critical first step for a career in professional nursing and the minimum educational requirement for professional nursing practice. While graduates can begin practice as an RN with an associate degree or hospital diploma, the BSN degree is essential for nurses seeking to perform at the case-manager or supervisory level or move across employment settings.

The BSN curriculum includes a broad spectrum of scientific, critical-thinking, humanistic, communication, and leadership skills, including specific courses on community health nursing not typically included in diploma or associate degree programs. These abilities are essential for today's professional nurse who must be a skilled provider, designer, manager, and coordinator of care.

A recent report by the National Advisory Council on Nurse Education and Practice, an advisory panel to the federal Division of Nursing, noted that baccalaureate nursing programs are far more likely than other entry-level tracks to provide students with on-site clinical training in non-institutional settings outside the hospital. As a result, the BSN graduate is well-prepared for practice in such sites as home health agencies, outpatient centers, and neighborhood clinics where opportunities are fast expanding as hospitals focus more on acute care and health services move beyond the hospital to more primary and preventive care throughout the community.

Aware of the expanding opportunities, RNs are seeking the BSN degree in increasing numbers. Between 1975 and 2000, the number of RNs (with diplomas or associate degrees) graduating from BSN programs rose from approximately 3,700 to 11,521 according to AACN data. Indeed, enrollment of RNs who returned to school full-time in 2000 to pursue the BSN degree rose more than 7% above the previous year. Such numbers indicate the high premium that nurses place on advanced education in today's growing market, and the demand by employers for RNs who are baccalaureate-prepared.

Unfortunately, in the nursing profession the question remains -- what makes a registered nurse? -- a two-year associate degree education, a three-year diploma education, or a four-year baccalaureate degree? The answer is that all levels and methods of educational preparation allow students to sit for the patient care-focused NCLEX-RN® exam and, if successfully completed, practice as a registered nurse. Confusing at best, students are not prepared to make well-informed decisions regarding which educational tract to pursue based on practice patterns or long-term career goals.

Creating a Career Destination of Choice

The current nursing shortage and the decreased interest in the profession are the results of multi-faceted issues including the evolving health care delivery system, the aging population, and the changing aspirations of young women who have traditionally made up the bulk of new nursing students. In contrast with the 1970's, a nursing career is not a desired option for most students.

The longitudinal American Freshman Study indicates that an extremely small percentage of college freshmen are choosing a nursing career. The J. Walter Thompson Company conducted a recent national assessment comprised of ten focus groups with students in grades 2 through 10 found that young children, particularly those who plan to seek a college education, do not see nursing as an attractive career option.

In 1995, a collaborative project of the AACN, the American Organization of Nurse Executives, and the National Association of Associate Degree Nursing resulted in a clear and bold statement of support for associate degree and baccalaureate nurses. These organizations' collective view was that the health system required nurses prepared at both levels of education and that graduates of these programs hold different competencies and should be valued for those differences.

Unfortunately, health systems employers have failed to clarify that different competencies are acquired in the different educational paths to nursing which has created another unexpected change in the educational system. Increasingly, anecdotal reports are heard that the shape of associate degree nursing programs is changing dramatically. A recent report from the Center for the Health Professions at the University of California-San Francisco validated these anecdotal reports. In the report, *Nursing in California: A Workforce in Crisis,* (2001) the authors revealed that California associate degree programs have widely divergent curricular structures with required credits ranging from 62 to 115 credits to graduate from a supposedly two-year program. Moreover, the authors report that it is virtually impossible to graduate from an associate degree program in three years and more frequently requires four years. The "credit creep" reflected in these findings is also accompanied by a growing tendency for associate degree educators to add community and public health experiences to the curriculum for the students in these programs.

This is a shift from the original intent of associate degree education as a two-year, fast track preparation for nurses who would then be employed to provide care for individuals with conditions that were both predictable and routine. One could question whether this is actually a possibility in the current, complex environment of health care. More likely, however, the diversification of the learning experiences for associate degree students and the growth in the number of credits required reflect the nature of the roles the graduates of associate degree programs are expected to fill.

The recruitment of young men and women into the nursing profession is at a critical low point threatening the integrity of the entire health system. AACN and other nursing leaders believe that to bring more students into the profession there must be a vision for professional progression, a pipeline from all educational levels of the registered nurse to alternative and advanced practice roles. The failure of the nursing profession to clarify the role expectations and educational outcomes for all levels of nursing will hinder efforts to recruit the best and the brightest into the profession.

Make Nursing Education More Accessible and Affordable

Nursing schools across the U.S. turn away thousands of qualified students each year due to an insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints. In the face of declining enrollments, schools are struggling to maintain current enrollment levels though an even greater influx of students is needed to meet the projected demand for nurses in the coming decade.

Adding to the problem is the fact that many of our nation's nursing schools are literally crumbling since funding support for infrastructures has not been granted by Congress since the mid-1970s. The cost to train nurses is comparatively high. Nursing schools require a high ratio of faculty to students, sophisticated clinical equipment, computer software, and simulated hospital units for student training. (State Boards of Nursing recommend a ratio of 1 faculty member to 8-10 undergraduate nursing students in clinical settings.) In addition, a nursing education is more expensive for students since they must purchase uniforms, stethoscopes, and arrange transportation to hospital and other practice sites.

Federal efforts to make nursing education more accessible and affordable occur primarily through the Nurse Education and Practice Improvement Act of 1998 (Public Health Service Act, Title VIII), known as the Nurse Education Act or NEA. Title VIII grant programs increase the number of nurses in the workforce at every education level as well as strengthen the ability of schools of nursing to educate students. Congress provided $78 million for the three Title VIII programs in FY 2001, however AACN and other members of the nursing community recommend an additional $25 million as a good first step in meeting the needs of the evolving nursing shortage.

The NEA focuses on three grant areas-- Advanced Education Nursing, Nursing Workforce Diversity, and Basic Nurse Education and Practice. In an effort to recruit and prepare disadvantaged students to become nurses, the NEA awards $4 million annually to Workforce Diversity Grants. Awards go to schools of nursing, Nurse-Managed Health Centers, academic health centers, state or local governments, and nonprofit entities looking to increase access to nursing education for disadvantaged students including racial and ethnic minorities under- represented among registered nurses. In addition, the program provides scholarships or stipends, pre-entry preparation, and retention activities to enable students to complete nursing education programs.

The NEA funds two nursing loan programs from Title VIII. The Nurse Education Loan Repayment Program (NELRP) was created to assist in the recruitment and retention of full-time registered and advanced practice nurses working in areas with nursing shortages. The NELRP provided loans of only 60% of the amount authorized to 50% of nurses applying for program participation. The NELRP has operated on a static budget of $2 million over the last five years. The Nurse Student Loan (NSL) program was created to address nursing shortages. It operates on revolving funds received through loan paybacks and returned funding received from nursing schools that have closed down. Congress last appropriated funding to address nursing shortages through the NSL program in 1983. AACN recommends an additional funding of $18 million for these two loan programs.

The Georgia Southern University Experience: Existing federal efforts to address nursing education involve the use of targeted grants and the dissemination of loans and scholarships. However, the nursing shortage has stimulated states and local areas to come up with creative solutions to recruit students into nursing and to make education more accessible to busy students with family and full-time jobs. Health care facilities, private industries, and schools of nursing are providing scholarships and loan forgiveness for nursing education so that employees and citizens will not go without basic nursing care. In addition, innovative public and private partnerships are being formed to fund creative practice sites and new educational facilities.

***Recruitment Efforts*:** Nursing faculty from Georgia Southern make numerous personal recruitment visits to area grade and high school students. They conduct health and career classes, emphasizing the academic requirements for and professionalism of a career in nursing. On occasion, they partner with the Magnolia Coastlands Area Health Education Center to recruit young people into the health professions. Minority groups and men (particularly EMTs and military corpsmen) have also been targeted. The School received U.S. Army Cadet Command Partnership in Nursing Education (PNE) status in order to attract military candidates for admission to the undergraduate program. Recruitment efforts, however, are limited by inadequate resources available to support faculty release time and travel expenses.

***Accelerated Educational Programs for LPNs, RNs*:** Educational programs have been created for Licensed Practical Nurses (LPNs) and RNs that offer these students an accelerated pathway to obtaining the BSN and MSN degrees. The time required to achieve a degree has been significantly reduced. Surrounding rural communities have requested that the School bring these educational programs to distance sites where large numbers of practicing nurses and ancillary personnel would be given tuition resources to continue their education in nursing. At the present time, limited faculty resources prohibit these initiatives from being implemented to their fullest potential.

***Distance Learning Options*:** Faculty created videoconference and WebCT courses that increased access to educational offerings for students in both the baccalaureate and graduate programs living in areas significantly isolated from campus. Additional courses and entire on-line degree programs are being planned for development, but currently lack sufficient faculty and equipment resources to be completed.

Increased Scholarship Support for Students: The School awarded over $80,000 in scholarships from its foundation monies to support students pursuing a degree in nursing. In particular, funds were targeted to students willing to commit to working in rural, underserved areas after graduation. Grant funds of $50,000 were awarded to LPN and RN students seeking the baccalaureate or master's degree and $45,000 in Federal Traineeship grant funds were given to graduate students pursuing an MSN. Faculty are eager to secure grant funding for additional scholarship resources for both graduate and undergraduate programs, but lack time and resources for writing these grants.

Nurse-Managed Health Centers: Since 1994, the School has operated a primary care nurse-managed health center in a rural community that was without a health care provider. Primary care nurse-managed health services are also provided to migrant populations in four surrounding rural counties. These sites provide practice, service, and research opportunities for both graduate and undergraduate students and faculty. They also provide health care services to underserved areas. These activities, coupled with the Community Nursing Center that will be located in a new Science and Nursing Building under construction, have the potential to create a strong support base for economic development in the region. Additional faculty with advanced practice certifications and research agenda are needed to expand educational and practice experiences for both graduate and undergraduate students in these outreach services.

Partnerships with the State/Regional Initiative and Local Health Care Agencies: The School of Nursing received a $400,000 gift from the Bulloch Health Care Foundation, Inc. to establish an endowed scholar for rural nursing education. Matching funds will be sought to build a $1 million endowment required for a Georgia Board of Regents Eminent Scholar. This scholar will create educational offerings as well as a research program that engages both graduate and undergraduate nursing students in developing a better understanding of and expertise in treating the unique health care needs of citizens in rural communities.

The School of Nursing has been recognized as a probable partner in the Georgia Cancer Initiative designed to improve and expand the delivery of cancer care to the state's citizens. The role of the School of Nursing, with funding to support a faculty position focused on oncology nursing care delivery and research, will be to increase the educational opportunities for nursing students and practicing nurses at all levels of education with a particular focus on the baccalaureate prepared nurse.

Faculty partnerships with the local hospital, East Georgia Regional Medical Center, resulted in the development of a program to train nurses as mentors to students and new graduates. Faculty worked with the hospital to achieve magnet status by increasing their involvement in committees and workgroups designed to improve working conditions for nurses. Pending available resources, plans are underway to re-establish a nurse extern program for new baccalaureate graduates and to develop joint leadership training initiatives for practicing nurses and undergraduate students.

***Critical Infrastructure Needs*:** Georgia Southern University broke ground on a new $24 million, 125,000 square foot Science and Nursing Building on June 5, 2001. Funded by the state of Georgia and scheduled for completion in Fall 2003, this facility will feature research and nursing skills laboratories, distance learning classrooms, and a community nursing center. The facility will enable the School of Nursing to attract increased numbers of students and qualified faculty to the Southeast Georgia region by enhancing the resources available to provide the technologically advanced learning experiences needed for educating the next generation of professional nurses.

***Transcultural Experiences*:** Faculty have successfully created and offered international learning opportunities for students at the graduate and undergraduate levels. This summer, students from both programs traveled to Ghana, South Africa where they had learning experiences in the direct delivery of nursing care in acute care and rural community settings. While there, faculty and students also conducted research in the areas of maternal-child care and HIV-AIDS care in Ghana. These experiences were directly paralleled to learning experiences students have in the School of Nursing's rural focused graduate and undergraduate curricula and health care environment.

Federal Response to Previous Nursing Shortages

To address previous nursing shortages, Congress acted decisively by funding new initiatives that effectively increased capacity in nursing schools and attracted new students to the profession. In response to a nursing shortage in 1964, Congress created the Nurse Student Loan program (Public Health Service Act, Title VIII, Section 836). Although the program increased opportunities for students to become nurses, it no longer is authorized to receive new funding.

In response to the nursing shortage of the 1970's, Congress created a capitation program that provided per capita funding to schools of nursing for support of nursing education programs from 1971-78. To qualify for capitation grants, schools were required to increase their enrollments above the previous year's enrollment level. Congress also required schools receiving these grants to pursue curriculum development, increase educational opportunities for disadvantage students, increase the supply of adequately trained nursing personnel, and promote the full utilization of nursing skills.

Congress has not addressed problems such as practice environments that hinder nurses' autonomy over their own practice, licensure, and entry-level practice roles that have been largely unrelated to education. Most efforts to deal with nursing shortages over time focused on recruitment programs or image campaigns and did not get at core problems that have plagued nursing for decades. Over the years Congress has authorized new programs through the NEA in response to nursing shortages. Unfortunately, there is no trigger mechanism to flip the on switch to reauthorize federal programs that have been effective in addressing nursing shortages of the past when nursing school enrollments begin to plunge.

Academic Solutions to Strengthen Nursing Education

AACN and the nursing community call for new initiatives in the areas of faculty preparation, enrollment incentives, and a post-baccalaureate residency program to minimize the impact the nursing shortage will have on our nation's health care system.

Create a Fast-Track Nursing Faculty Scholarship and Loan Program: Providing scholarships and loans to students to become nurses is ineffective if faculty do not exist to educate them. To increase the number of nurse educators, a Fast-Track Nursing Faculty Scholarship and Loan Program is needed to provide economic incentives to master's and doctoral students to commit to serving as faculty members at baccalaureate- or graduate-level nursing schools. Such a program should require participating students to serve as a nurse educator at a college or university for a number of years equivalent to the number of years the participant receives federal support. With $30 million in FY 2002, a fast-track faculty program could provide non-taxable scholarships, loans, and stipends to allow 1,500 nursing students to pursue full-time graduate study. AACN recommends giving preference for the fast-track program to doctoral students as the doctoral degree is the appropriate and desired credential for nurse educators. In addition, preference should be given to minority and needy students, allowing others to participate after requests from minorities and needy students are filled.

With federal support, nursing schools could recruit their most talented students from a pool of over 103,000 baccalaureate students to enter the pipeline to become faculty members. Without federal support, less than 1% of baccalaureate nursing students are expected to become faculty members.

Establish a Capitation Grant Program: Schools of nursing must have strong infrastructures equipped with current technological equipment and labs to provide nursing students with the complex level of education required to practice nursing in today's health care system. A Capitation Grant Program is needed to strengthen the abilities of nursing academia to recruit and retain students and faculty, enhance classroom/lab space and support the nursing school infrastructure. AACN recommends creating a capitation program to provide an incentive to recruit new students and retain faculty with federal support of $1,200 for each full-time equivalent student enrolled in a collegiate school of nursing. Schools of nursing should use capitation funding to meet their individual program needs in increasing nursing students enrollments.

To qualify for capitation grants, schools should be required to increase their enrollments by 5% or five students—whichever is greater— above the previous year's enrollment. In addition, they should be required to provide assurances that they would increase their first-year enrollments over a base year, which was the average of the two highest enrollments in the previous five school years, by 5% or ten students, whichever is greater. The Secretary could waive this requirement if the school's facilities limit it from enrolling additional students.

Note: In January 1974, the Institute of Medicine Cost Study endorsed a capitation grant program as an appropriate federal undertaking to provide a stable source of financial support for the health profession schools, including nursing. It recommended that capitation grants ranging between 25% and 40% of net educational expenditures would contribute to the financial support for the stability of health professions schools.

Create a Post-Baccalaureate Nursing Residency Program: A Post-Baccalaureate Residency program is needed to recruit and retain baccalaureate nurses in the profession. In addition to insuring the successful transition of the newly licensed professional nurse from student to expert nurse, a nursing residency will insure that our nation's health care team includes nurses with a high level of education and clinical experience. Stabilizing the health care team with well-educated nurses with bachelor or higher degrees will also provide a positive image of nursing and attract more highly qualified applicants to the profession.

Nursing residencies should target specialty areas since nurses who have moved up the career ladder to fill those roles are older and exiting the profession. These include hospital emergency and operating rooms, acute and critical care units, and community settings such as long-term care facilities.

A residency program will minimize the burn-out associated with the stresses of under-preparation for the nursing role, which is causing our young nurses to leave the profession. In addition, a post-baccalaureate residency program will keep new baccalaureate-nurses in the profession by providing them with socialization and cultural skills of the practice site, knowledge of policies and procedures, and technical proficiencies to cope with the reality and challenges of caring for the acutely and chronically ill.

The residency program would provide recognition of the enhanced value of the baccalaureate degree at the federal level, on campuses, and in health care settings. Currently, diploma, associate- and baccalaureate-prepared nurses are equally licensed as RNs, equally compensated by employers, and often delegated identical responsibilities.

Needs of the Georgia Southern University School of Nursing: The Georgia Southern University School of Nursing requires additional support in four major areas: recruit ten new faculty members, improve grant-writing initiatives, improve Internet technology and distance education opportunities, and develop clinical laboratory experiences for students.

Faculty Support: In order to expand the capacity for educating entry-level and advanced practice nurses, the Georgia Southern University School of Nursing requires a minimum of five additional full-time tenure track faculty, at least three with advanced nurse practitioner credentials and one non-tenure track faculty is needed to coordinate the clinical skills laboratory in the School of Nursing in addition to increasing the number of adjunct faculty.

Opportunities exist to bring an entire program of study to several counties in rural areas in Southeast Georgia. For example, the School of Nursing has been approached by a health care agency in Millen County requesting that the undergraduate program be brought to their hospital campus. Over 30 potential students have expressed a strong interest in pursuing a baccalaureate degree in nursing and the agency has agreed to cover all tuition expenses. Similar requests have been received from other regional communities. One to two additional faculty would be needed to manage programs such as this.

An opportunity exists for the School of Nursing to be an active participant in the Georgia Cancer Initiative in the area of educational preparation of nurses skilled in the delivery of oncology care. If the school can recruit a nationally known oncology nurse specialist/educator/researcher, it will enhance the School's ability to participate in this initiative.

An opportunity exists to collaborate with the Georgia Washington University Adult Nurse Practitioner to Family Nurse Practitioner Program that prepares adult nurse practitioners to become family nurse practitioners. The School is considering being the "southern contingent" of this program. This collaborative effort could begin as early as Fall 2000, but would require additional Family Nurse Practitioner faculty.

Grant Writing and Faculty Development Support: Support is needed to access the monies available for curriculum development and research addressing rural and underserved populations. At the current time, faculty are extremely limited in their ability to attend state and national conferences related to health care delivery and professional nursing initiatives. The School's current budget is used to support faculty travel to distant clinical education sites ($10,000 this past academic year). Increased travel support is necessary to expand the national presence of faculty and the School. In turn, such exposure would positively impact innovative instruction and curriculum redesign as well as stimulate continuing interest in careers in academia.

Clinical Laboratory and Technical Support: The School needs support for an array of technology concerns such as providing technical personnel support and technology resources to assist faculty in developing Internet based courses for both the undergraduate and graduate programs. There is a nationwide need to increase the availability of Internet courses and programs for BSN, RN-BSN, and graduate core/advanced practice, which the School could develop. Additionally, reconfiguring the School's Rural Community Health Nurse Specialist major to an

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on-line program would enhance graduate applicants and would be a first for Georgia.

The School needs support to upgrade and expand its clinical laboratory, media, software, and Internet subscription resources—particularly to maintain cutting edge curricula and learning experiences and to expand offerings into distance learning and on-line programming. A state-of-the-art laboratory facility will make continuing education partnerships with community health care agencies possible. Additional personnel in the clinical laboratory is critical to maintaining and expanding the use of the lab as a simulated clinical environment and learning/assessment center.

Resources are needed to increase the number of clinical learning environments for students in both graduate and undergraduate programs and practice environments for faculty. With the construction of the new Science and Nursing Building, the Community Nursing Center in the building will provide expanded opportunities for outreach and service. The School is also exploring the possibility of pursuing grant opportunities to purchase a clinic van that could be used to deliver nursing care to rural communities, thus impacting the economic development of the region.

Conclusion

Once again, another cycle of nursing shortages is wreaking havoc in the health care delivery system. Popular solutions focus on short-term strategies such as immigration, sign-on bonuses, increased overtime, and pay raises. Market forces cause scarce nursing resources to go for the best financial opportunity in an acceptable practice environment.

As the Congress investigates solutions to the current shortage, it must focus on the long-range issues that affect the nursing profession. While concerns about salary must be addressed, steps must also be taken to evaluate and improve the practice environment. Simultaneously, schools of nursing must be adequately funded to strengthen and expand the capacity to educate the nursing workforce for the coming century. However, the nursing profession and other dedicated stakeholders must take the bold step to define the education and training requirements and practice competencies for all nursing care providers.

The nursing profession must create a career pathway so that nurses can remain engaged in the profession. Nurses must envision taking on different aspects of health care delivery and alternative nursing roles. Though these opportunities may take nurses away from the traditional practice at the hospital bedside, it creates a positive career trajectory that will keep nurses in the field and attract fresh talent to maintain staffing levels. The nursing profession will always need to have a continuous flow of young new nurses to carry the burden of an intellectually stimulating, physically challenging, but incredibly rewarding career.

APPENDIX J - WRITTEN STATEMENT OF CATHERINE GARNER, DrPH, RN, FAAN, DEAN, COLLEGE OF NURSING AND HEALTH SCIENCES, UNIVERSITY OF PHOENIX, PHOENIX, AZ

Testimony of Catherine Garner, DrPH, RN, FAAN

Before the Committee on Education in the Workforce

September 25, 2001

Chairman Boehner, members of the Committee, it is a great pleasure to appear before you today to discuss some innovative educational initiatives to address the nation's nursing shortage.

The University of Phoenix is the nation's largest private University, with over 120,000 students in over 90 campuses and learning centers in the United States, Puerto Rico, and Canada. Our 26,000 on-line students are able to complete their education even if they move frequently or travel. Founded in 1976, the University of Phoenix is dedicated exclusively to working adults. Phoenix offers degree programs and professional certificates in many high demand fields, including: Business, Technology Management, Information Systems, Education, Counseling, Nursing, and Criminal Justice.

The University of Phoenix College of Health Sciences and Nursing offers National League for Nursing Accreditation Commission (NLNAC) accredited programs for the Bachelor of Science (BSN) and the Master of Science in Nursing (MSN), including our Family Nurse Practitioner Program. In just ten years, the Nursing Program has grown to our current enrollment of over 2000 undergraduate and 1800 graduate nursing students at 36 campus locations in 10 states. Over 1000 of our nursing students are going to school exclusively on-line. Our present student body is 37% minority and 10% male, with an average age of 37. Our growing enrollment and the diversity of our program is due to three key factors: the Phoenix teaching-learning model for the working adult, our just-in-time curriculum development process, and our expert practitioner faculty.

The University of Phoenix offers one course at a time, with on-ground class attendance one night a week. Students also meet in learning teams once a week, a process that replicates the typical multi-disciplinary work environment. The classes are purposely kept small to encourage active participation, leveraging the combined experience of the whole class. Class faculty student ratios average 1:15 for on-ground and 1:10 for on-line.

Expert clinicians, faculty, and employers continuously revise our curriculum in an effort to provide the most relevant curriculum in today's rapidly evolving health care environment. An extensive on-line library collection, custom textbooks, interactive learning technologies, web links, and writing lab support the curriculum.

Our 300 plus nursing faculty are either doctorally prepared or masters prepared with five years experience. Our practitioner faculty members work full time in their professional practice and teach for us on a course-by-course basis. We have no trouble recruiting high caliber, academically qualified faculty, despite the fact we have no full-time career track of tenure system. Our faculty includes chief nursing executives, state board of nursing staff and members, managed care professionals, chief financial officers, and every clinical care specialty.

Our nursing education establishment must embrace the concept of public –private partnerships to deal with the increasing shortage of health professionals at a time when the workplace requires greater skill and advanced critical thinking. The traditional four year college based BSN programs are rapidly loosing ground, as we look again to the roots of traditional nursing: vocational development in high school, strong community college Associate RN degree programs that articulate into BSN/ MSN programs designed to enable our students to work and support their families.

In fact, there are many men and women wanting a nursing career, as seen by the 2-3 year waiting lists for many community college nursing programs across the country. A majority of those waiting are ethnically diverse, non-traditional students, who must work to support families. The traditional semester, daytime class model is not designed to support their success. We must actively work to develop alternative models of delivery and to encourage the innovators.

In a number of communities, the University of Phoenix is partnering with the Community College system and a number of local hospital employers to double the number of one year community college Licensed Practical Nurse (LPN) graduates, who then articulate seamlessly into the University's 30 month LPN to BSN program. The LPN is able to go to school while working full time in his chosen profession. Hospital employers are enabling these students by providing tuition support, facilitating clinical work, and providing nurse mentors from their own staffs. This program will be offered on line to the over 900,000 working LPN's across the country to encourage them to move into the RN role. The program will also be offered to active duty medics in our armed services, who will be able to complete the BSN degree while on active duty, thus promoting the 2005 goal of an all BSN nursing corp.

The distance education model affords educational opportunities in rural areas as well as allowing those nursing students who work odd shift hours to pursue education at their own convenience. The on-line student cohorts bond quickly and provide a positive support system for each other as well as cross-country sharing of expertise. In December, our first national cohort of nurses working in the nation's 38 Children's Hospitals will start their on-line masters degree classes.

We hope that the committee will consider the following recommendations that we believe would help promote nursing education and nursing careers:

Tuition/loan forgiveness programs. There are several bills pending in the House and the Senate that would create new scholarship/loan forgiveness type programs at the Department of Health and Human Services for students pursuing a nursing education. These programs help recruit students into nursing and help keep them in the profession after completing their education. However, new programs are not needed. This Committee oversees the largest student loan program in the country that serves millions of students each year. If you were to consider adding a loan forgiveness component for nurses to the existing student loan program similar to the one you created for teachers, it would be the most efficient way of promoting recruitment and retention efforts.

Innovative delivery programs. In order to expand the number of people who enter the nursing profession, we need to target working adults looking for new and better opportunities and adults reentering the workforce. This means colleges need to be able to offer innovative and flexible programs and schedules. We are not talking about 18-year old traditional college students who can spend all day in class. Congress and the Department of Education need to change laws and regulations that create roadblocks to expanding educational opportunities for nontraditional students. That is why many of us in the higher education community greatly appreciate your efforts to expand on-line education by supporting HR 1992 which will allow colleges to reach more nontraditional students.

Employer Awareness of Education Support as an Effective Recruitment/ Retention Tool. Employers should be encouraged to use employee tuition reimbursement as an effective recruitment and retention tool. The Veterans' Administration Medical System is a national model for this approach.

APPENDIX K - WRITTEN STATEMENT OF GEORGE F. LYNN, PRESIDENT AND CEO, ATLANTICARE, TESTIFYING ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, D.C.

Testimony of the
American Hospital Association
before the
United State House of Representatives
Committee on Education and the Workforce

"The Nursing Shortage: Causes, Impact and Innovative Remedies"

September 25, 2001

Mr. Chairman, I am George Lynn, president and CEO of AtlantiCare, southeastern New Jersey's largest health care delivery system. I am here today as a member of the Board of Trustees of the American Hospital Association, representing the AHA's nearly 5,000 hospital and health system members. Thank you for this opportunity to testify on the immediate and long-term shortage of nurses and other health care workers.

Mr. Chairman, I would like to state, on behalf of the entire hospital community, how proud we are of our colleagues in New York, New Jersey, the Washington, D.C. area, and across the country, as they responded to the terrorist attacks on September 11. Physicians, nurses, emergency personnel and all members of the health care workforce provided care and relief to those in need, and we are fortunate as a nation to have such individuals who have dedicated their lives to the health care field.

AtlantiCare is an integrated network of health care services, encompassing Atlantic City Medical Center (ACMC), a 581-bed, two-division teaching medical center with more than 2,000 employees. Over its 100-year history, ACMC has grown from a 10-bed facility in a converted home, to a regional health care system and teaching institution. Our staff is comprised of more than 2,400 caregivers, including 800 registered nurses and 350 physicians in 30 medical and surgical specialties, all dedicated to our organization's philosophy: Patients are the Center of Everything, or PACE. ACMC is also home to many centers of excellence and specialized services, several of which are exclusive to the region. These include a new cardiac surgery program; a level II regional trauma center; a neonatal intensive care unit, a joint and spine institute, a pediatric special care unit; the Ruth Newman Shapiro Regional Cancer Center; the Kligerman Digestive Disease Center; in-house state-of-the-art MRI; and the region's only hospital-based infectious disease and sub-acute care unit.

In 2000, ACMC cared for more than 238,000 outpatients and admitted more than 21,000 patients. As with many hospitals across the country, the population we serve is aging and growing in number, increasing the demands on our health care delivery system. This, coupled with drastically declining funding for hospitals, presents a myriad of challenges for health care institutions that strive to offer quality care while remaining financially stable.

Background

One of the greatest challenges we face is the current and future shortage of health care workers, the very essence of our field. Without enough caregivers, hospitals may be unable to fulfill their mission to care for patients. This widespread shortage affects x-ray technicians, nurses aides and pharmacists, where today one in five positions is vacant. While the shortage is apparent almost across the board in health care, the most striking shortage is for nurses, many of whom provide important bedside care. A recent survey of AHA members found that of 168,000 vacant hospital positions, 126,000, or 75 percent, are for registered nurses.

Every day, nurses care for America's patients in hospitals, medical centers, clinics and physician offices. Their work can be arduous and physically demanding, especially when faced with high levels of stress due to staff shortages, budget shortfalls, and an increase in the number of patients and the severity of their illnesses. Today's nurses are frustrated with their work environment, especially when they spend more time on paperwork than patient care. A recent study found that every hour of care in the emergency department requires one hour of paperwork.

Nursing is one of the most difficult professions. In the past it has attracted many young women and some young men for a number of reasons, including the feelings of satisfaction from helping an accident victim walk again, caring for a critically ill newborn, or being thanked by a cancer patient for seeing him through his chemotherapy. But lately, even these rewards are not enough to attract young people to the health care profession. There are simply many other career opportunities available. Nursing is no longer the favored career it once was.

Factors Contributing to the Shortage

The current nursing shortage differs from those of previous years, which were largely a function of fluctuations in the economy. Now, several complex factors contribute to the shortage of nurses: a shrinking supply of experienced nurses due to an aging workforce; a dearth of younger nurses to replace those who retire; and a general increase in the demand for health care.

According to Peter Buerhaus et al. (*Implications of an Aging Registered Nurse Workforce, JAMA, June 2000*), the number of registered nurses under the age of 30 dropped by 41 percent from 1983 to 1998. The National Sample Survey of Registered Nurses for 2000 reported that the RN population under 30 has reached a new low of 9 percent of the total RN population. After 2010, the demand for health care and nursing services is expected to increase as baby boomers continue to age, while the supply of nurses will continue to decline. Buerhaus and colleagues state that the average age of nurses remaining in the workforce after 2010 will increase from 45 today to 50. Without an influx of young people into the profession, the increasing demand for nurses will lead to an even greater shortage in the near future.

Overall enrollment in basic RN programs has declined by over 50,000, or 22 percent, since 1993. Further eroding the supply of new nurses is the explosion in career opportunities for women, who make up about 95 percent of the nursing workforce. This phenomenon alone has greatly contributed to the decline in the number of college-bound women entering the nursing field. Less than 2 percent of college freshman indicate nursing as a likely major. Unlike the teaching profession, nursing has failed to attract men to its ranks in any significant number. In addition, many nursing programs have been forced to cut back because of faculty shortages (the average age of nursing school professors is 52), lack of clinical training sites and insufficient classroom space.

At the same time, 78 million baby boomers are approaching retirement age, and their demand for health care resources is increasing. Due to medical advances, we are diagnosing and treating cancer, heart disease and orthopedic conditions at an earlier age. Thus, our hospitals are already experiencing the impact of this generation of Americans long before they are eligible for Medicare.

While hospital nurses generally earn more than their counterparts in doctors' offices, home health agencies, nursing homes and other non-institutional settings, they may seek lower-paying jobs in less stressful working environments, further exacerbating the problem.

What is the impact of these shortages? Decreased access to care. Some hospitals are being forced to reduce the number of inpatient beds available, postpone or cancel elective surgeries, and tell ambulances to bypass their overflowing emergency departments. All because of a severe shortage of nurses and other essential health care workers.

Today, hospitals compete with each other and with private companies, like HMOs and pharmaceutical companies, for the dwindling pool of nursing professionals. As these private entities provide nurses with more attractive work environments and opportunities in different capacities, hospitals must still care for patients 24 hours a day, seven days a week, who are older, sicker and require a greater intensity of care from nurses and other health care personnel. While most current nurses were attracted to the nursing field because they wanted to care for people, more and more of their time is taken up with paperwork, leaving less time for hands-on patient care. In addition, as their colleagues leave the hospital setting for other employment opportunities, nurses who remain at the bedside often experience a greater sense of frustration, and may have to work more hours, care for more patients, and perform a wider range of duties.

Finding Solutions

We all need to recognize that nurses are a valuable national asset, and one that we cannot afford to lose. Finding solutions will require a multi-dimensional collaborative effort among hospitals, health systems, educational institutions and professional organizations. These efforts include providing incentives to choose nursing as a career, redesigning the work environment to make it more attractive, and establishing unique programs within each health care facility to assist nursing staff in obtaining a balance between work and home life. But assistance is also needed to increase the supply of nurses and help hospitals attract and train experienced personnel.

Several bills have been introduced in the House of Representatives and the Senate, seeking to expand the supply of nurses. These workforce proposals before Congress, which the AHA has endorsed, are critical to our efforts.

The Nurse Reinvestment Act, (H.R. 1436), a bipartisan bill sponsored by Representatives Sue Kelly (R-NY) and Lois Capps (D-CA), would establish a national nursing service corps to provide scholarships to nurses who commit to serving in a health facility that has a critical nursing shortage. It also expands Medicare and Medicaid funding for clinical nursing education. Its companion bill, S. 706, has been introduced by Senators John Kerry (D-MA) and James Jeffords (I-VT).

The Nurse Employment and Education Development Act (S.721), introduced by Senators Tim Hutchinson (R-AR) and Barbara Mikulski (D-MD), is another bill that would provide grants to develop recruitment and retention strategies, and scholarships and loans to encourage nurses to pursue graduate degrees for teaching.

Over the past few years, especially in the wake of the Balanced Budget Act's (BBA) deep Medicare and Medicaid payment cuts, hospitals have been forced to reduce or even eliminate critical patient services. Enactment of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act helped return some funds to hospitals, but most of the cuts have not been restored. Hospitals still face skyrocketing costs for labor, which accounts for more than 70 percent of a hospital's budget.

Adequate government funding is essential to helping hospitals attract and retain experienced personnel. Since overall hospital margins have been reduced due to the BBA cuts and rising costs, funds to increase wages have been limited. Congress should enact several proposals that would afford hospitals the opportunity and flexibility to address rising labor costs:

- The American Hospital Preservation Act of 2001 (H.R. 1556), introduced by Representatives Mark Foley (R-FL) and Richard Neal (D-MA), provides a full inflationary payment (market basket) update for FY 2002 and 2003. The market basket, Medicare's measure of inflation, is intended to measure the annual growth in prices faced by hospitals in delivering care to

Medicare beneficiaries. Rising labor costs dictate that the market basket update keeps pace with these increases. With the Medicare program not even providing a full inflationary increase to hospitals, we cannot deal with the reality of providing fair and reasonable wage increases. H.R. 1556 also acknowledges the higher costs teaching hospitals incur to provide adequate learning experiences and faculty support to medical students by maintaining the indirect medical education adjustment at 6.5 percent for FY 2003 and beyond.

- The Area Wage and Base Payment Improvement Act (H.R. 1609), introduced by Representatives Phil English (R-PA) and John Tanner (D-TN), recognizes that the severe shortage of caregivers, especially nurses, has driven wages higher, increased competition for these workers, and created an increasingly "national" market for hospital labor. H.R. 1609 establishes a "floor" on the Medicare wage index to help improve workforce compensation. It also creates a national standardized rate for the Medicare inpatient base payment by eliminating the difference in payments between large urban hospitals and other hospitals located in rural and smaller metropolitan areas.

AHA Workforce Commission

If we do not have the highly qualified women and men devoted to providing care, our ability to provide health care services for an aging population will be severely affected. That is why the AHA convened the Commission on Workforce for Hospitals and Health Systems. (A copy of the press release announcing the formation of the Commission and the list of its members is attached.) It is charged with identifying strategies to increase recruitment, retention and development of experienced caregivers and support staff as well as making hospitals and health systems "employers of choice." Because this issue has many stakeholders, the AHA has brought together a diverse group that includes hospital administrators, caregivers, academics, business leaders, professional nursing organizations, organized labor and many others.

During the coming months, the Commission will develop essential, strategic and tactical recommendations based on five key themes:

- Broadening the base;
- Partnering with others;
- The work partnership;
- Work design; and
- Societal support.

The Commission's work will culminate in a report released at the AHA's April 2002 Annual Meeting - a blueprint of solutions that will also be shared outside the health care field with government leaders and a variety of professional groups including educators, labor and technology leaders.

Hospital Initiatives

Health care administrators are constantly looking for ways to develop innovative working environments and promote nursing as a career. However, health care is not like the manufacturing industry, with a predictable production schedule. We never know when or how many patients will walk through our door on any given time day or night. We do not know how sick they will be or what type of service will be required. We have no control over flu outbreaks, highway accidents, national disasters or the scores of other health conditions that we attend to on a daily basis.

Hospitals cannot turn patients away, even when personal illnesses or family emergencies keep nurses from their shifts, so each hospital uses a variety of techniques to ensure adequate staffing for patient care. These may include:

- Requesting nurses or other staff to work voluntary overtime.
- Contacting staff who are paid to be "on call."
- Scheduling workers through a hospital's in-house staffing pool.
- Contacting a for-profit staffing agency outside the hospital.

Some hospitals may be forced to resort to mandatory overtime. But let me be clear: mandatory overtime is a hospital's tool of last resort. It is expensive and unpopular, but the only alternatives would be reducing or shutting down services, which is unacceptable to us and the communities we serve. Mandatory overtime is a symptom of the severe shortage of health care workers. The only solution is an adequate supply of well-trained nurses. But with the aging of the health care workforce, increased demand for services, and dropping enrollments at nursing schools, the workforce shortage in hospitals could easily reach crisis proportions.

To overcome this shortage, hospitals must employ innovative recruitment and retention strategies. Hospital administrators report using a number of incentives to minimize their current shortages. These include flexible hours; bonuses; child care assistance - either on-site or with a stipend; relocation bonuses or assistance; pay differentials for weekend and holiday hours; more attractive benefits packages; transportation assistance; housing allowances or subsidies; and salaries that are competitive with increases in the local market. With programs like these, hospitals are striving to be employers of choice.

Fortunately, ACMC's current RN vacancy rate is lower than the national average. This is partly due to the wide scope of nursing opportunities in our health care system, from neonatal intensive care to hospice care. Our success is also due to a number of initiatives aimed at attracting and retaining qualified nurses. These include typical strategies, many of which were suggested by our staff, such as flexible hours, signing bonuses, and enhanced compensation and benefits strategies. They also include innovative strategies such as a hospital-sponsored RN to bachelor of science in nursing educational program; and hospital-funded scholarships for nursing students who commit to joining our staff upon completion of their education. We also provide 100 percent tuition reimbursement for current employees who wish to pursue a career in nursing, and offer bonuses to employees who refer family or friends to our organization. Our merit compensation program is yet another incentive aimed at motivating and rewarding our nurses who perform well and have extended employment with our hospital.

Recognizing that child care may be problematic for some employees, ACMC provides on-site child care. Currently, 78 employees take advantage of this benefit. The facility is open seven days a week for children aged six weeks to six years, though in the summer we care for children up to age eight. ACMC subsidizes 20 percent of the cost, and offers additional assistance based on employee income.

At ACMC, we initiated the ACTION Project, a team comprised of nurses and other caregivers, to create a nursing model that enhances patient care, while improving the workplace environment. The result of this innovative effort was the implementation of an Admissions Team and a new Care Delivery Model.

ACMC is partnering with our local schools and community organizations to sponsor programs such as "Health Career Clubs" and the "Junior Volunteers." In addition, ACMC has awarded scholarships to minority high school graduates and to dependents of current employees. Scholarship recipients are mentored by senior nurses throughout their education to provide support and encouragement and, hopefully, help them complete their education and join our staff.

These solutions are proactive and creative, and they are working. But as good as they are, they are not enough. Finding long-term solutions is more difficult and will require a collaborative approach from all stakeholders, including hospitals, academia, professional organizations, and our local, state and federal governments.

In order to ensure the safety of our employees, hospitals work diligently to ensure a safe work environment for everyone, including nurses, and adhere to ergonomics safety methods, a key employee safety priority. Many hospitals undertake comprehensive ergonomics risk management programs to enhance and ensure the safety of the workplace environment. One such program is the Caregivers Optimal Safety Transfer System, available through AHA Financial Solutions Inc., a subsidiary of the AHA. For example, hospitals investigate work practices to determine if modifications are necessary to enhance safety, such as incorporating appropriate stretching into the work culture to prevent ergonomics injuries. Hospitals and health systems also purchase state-of-the-art equipment, such as "total care" patient beds that include devices to weigh a patient and also assist in lifting and positioning the patient in bed. But investing in this ergonomic technology can be a serious challenge to hospitals with revenues limited by inadequate payments determined by Medicare, Medicaid and private insurers.

ACMC's own workplace safety task force is comprised of an occupational medicine physician, the director of security and several safety officers, all of whom work to provide a healthy, safe and comfortable work environment for our nurses.

While ACMC and other hospitals are employing strategies such as these to retain current health care workers, we are examining how to attract the next generation of nurses, therapists and other caregivers. Many hospitals support advanced training and education for staff aspiring to a more fulfilling health care career as a nurse or other caregiver. Some have set up partnerships with local nursing schools and community colleges. And still others are reaching out to their communities and enlisting the help of retired military personnel and other professionals who may have finished their first careers.

A recent Government Accounting Office (GAO) study reported that wages can have an impact, both short and long-term, in the size of the nursing workforce pool. The report indicates that from 1989 to 2000, RN earnings have just kept pace with the rate of inflation. Hospitals and health care providers have made every effort to develop and implement wage and benefit packages which are fair and reasonable. However, reductions in reimbursement under Medicare as a result of the BBA, coupled with the growth of managed care, has had an impact on the ability of hospitals to develop more generous benefits packages. Over the past 17 years, the Medicare program has provided a full market basket increase to hospitals only three times.

Even with those financial pressures, RN wages at ACMC have exceeded the rate of inflation over the past five years. Since 1996, our nurses' salaries have increased over 25 percent. For the last three years, these salary increases have averaged over 4.8 percent per year. Many of my colleagues in the hospital and health care field will echo our experience. But these wage increases, along with the reductions in reimbursements, are stretching hospital budgets to the brink.

Conclusion

Mr. Chairman, we have a critical shortage of health care professionals. Today's focus on the lack of nurses illustrates the impact this will have on our hospitals' ability to continue providing appropriate high quality health care that our patients, friends and communities expect. In order to avoid a greater crisis, every stakeholder must work together to respond to this growing problem. In order to properly care for our patients - today and in the future - we urge you to support H.R. 1436 and other initiatives to expand the nursing workforce, if we are to promote nursing as a career in order to meet the growing health care needs of our nation.

Attachment A

NEWS RELEASE

FOR IMMEDIATE RELEASE
Contact: Christina Pearson (202/626-2342)
Alicia Mitchell (202/626-2339)

AHA Leads Efforts to Address Growing Workforce Shortage

Board Announces Blue Ribbon Commission to Undertake Year-Long Study on Looming Problem

Washington (January 31, 2001) - Recognizing one of the most significant problems facing the health care field, the American Hospital Association's (AHA) Board of Trustees has voted to launch a commission aimed at affecting the immediate and long-term shortages of health care personnel.

Combined pressures - a shrinking workforce, an aging population, financial concerns, increased demand and other stresses - have translated into a severe personnel deficit at our nation's health care facilities. The commission is charged with identifying strategies to increase recruitment, retention and development of qualified caregivers and support staff in hospitals. The Board also adopted an interim policy statement, entitled "Workforce Supply for Hospitals and Health Systems -- Issues and Recommendations," that will serve as a framework for the commission's work.

"Our members on health care's front lines have warned us: today's personnel shortages reflect the beginning of a critical, long-term challenge for hospitals," AHA President Dick Davidson said. "The aging of the 'baby boom' generation, among other factors,

means that the demand for health care services is increasing - at the same time the size of the workforce decreases. America's hospitals must take aggressive action now to head off this impending threat."

Comprised of experts from within and outside health care, the commission will develop and issue a final report at AHA's Annual Meeting in April 2002. The chairman and members of the blue ribbon panel will be announced at a later date.

Without sufficient numbers of personnel, America's hospitals will not be able to meet the growing health care needs of their communities. The interim policy statement notes that shortages are not limited to any one occupation. Though the nursing shortage has received much attention, hospitals also face a decreasing applicant pool of pharmacists, technicians, technologists, therapists, housekeepers, food service workers, information service specialists, medical record coders and others.

AHA's interim policy statement on the workforce identifies several issues and solutions to be considered by the commission, such as:

- *Fostering educational opportunities* - Hospitals need to consider innovations that encourage present staff to obtain additional training and enter new careers in order to facilitate career development, upward mobility and increased employee tenure.

- *Broadening applicant pools and increasing the attractiveness of health careers* - Hospitals and health systems need to broaden their workforce initiatives to reach people that have not traditionally been employed throughout health care. For example, the pool of nursing applicants has been and remains primarily female.

  Meeting the workforce challenge will require expanding the applicant pool.

- *Investing in innovations that establish a competitive work environment* - Hospital leadership should consider increased usage of flexible employee work schedules and information technologies that reduce manual documentation and repetitive administrative tasks. New technologies, which allow staff to emphasize the care giving functions of their positions, are essential for hospitals to attract, develop and retain employees.

- *Reviewing compensation strategies* - Some hospitals have found incentive compensation programs and other approaches that appeal to workers.

  To receive a copy ot AHA's interim policy statement, go to AHA's website or contact Christina Pearson (202/626-2342) or Alicia Mitchell (202/626-2339).

The AHA is a not-for-profit association of health care provider organizations and individuals that are committed to health improvement of their communities. The AHA is the national advocate for its members, which include 5,000 hospitals, health care systems, networks, other providers of care and 37,000 individual members. Founded in 1898, the AHA provides education for health care leaders and is a source of information on health care issues and trends. For more information, visit the AHA website at www.aha.org.

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APPENDIX L – SUBMITTED FOR THE REOCRD, STATEMENT OF CONGRESSWOMAN LOIS CAPPS, 22ND DISTRICT OF CALIFORNIA, U.S. HOUSE OF REPRESENTATIVES, SEPTEMBER 25, 2001

LOIS CAPPS
22D DISTRICT, CALIFORNIA

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Congress of the United States
House of Representatives

Statement of Congresswoman Lois Capps
Nursing Shortage
Committee on Education and the Workforce
September 25, 2001

Mr. Chairman, thank you for holding this hearing on such an important and pressing issue. It is especially clear after recent events that we need to make sure that our public health infrastructure is secure and able to handle the kind of burden that will be placed on it.

I have been a nurse for 41 years and I have been working on this issue for nearly two years here in Congress. As a nurse I have first hand knowledge of the challenges my profession faces and of the importance of nurses in the health care system.

The nursing workforce is facing a crisis that needs to be addressed now. We have an aging nursing workforce and a dwindling supply of new nurses. Right now the average age of employed Registered Nurses is 43 years old. By 2010, 40% of the RN workforce will be over 50. In contrast, the number of RNs under 30 declined 41% between 1983 and 1998. And the number of graduates from nursing programs declined 13.6% between 1995 and 1999.

With so many nurses approaching retirement, and decreasing numbers of young people taking up nursing as a calling, we are facing an incredible shortfall of well trained, experienced nurses in all fields. To make matters worse this will happen just as the 78 million members of the baby boom generation begin to retire and need a greater amount of care.

In my home state of California, the problem is even worse. Less than 10% of the RN workforce back home is under the age of 30 and nearly a third are over the age of 50.
California already ranks 50th among the states in RNs per 100,000 people.

Part of the problem is that the nursing workforce is so homogeneous. The vast majority of nurses are white women. Fifty years ago, a smart young woman had only a handful of career options available to her, including nursing. But as our society's views on women's equality have progressed, we have not escaped the perception that nursing is "women's work."

As young women have explored different careers, very few young men have entered the nursing workforce to replace them. Right now less than 6% of the nursing workforce is comprised of men. Likewise, even though the percentage of minorities in our national workforce has risen to close to 25%, minorities still only represent 10% of all RNs.

In order to deal with this looming shortage we are going to need to address a number of issues and be creative in our solutions. We need to draw more people into the profession, particularly

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the young men and women at the high school level who are choosing their career paths. We need to reach out to minorities and disadvantaged youth. We need to retain those nurses who are already in the workforce. And we need to make sure we have enough nursing school faculty, mentors, and preceptors to properly educate and train our workforce.

I have been pleased to work with Representatives Kelly and DeLauro, Senators Kerry and Jeffords, and various nursing groups to craft legislation on this matter, the Nurse Reinvestment Act. Our bill establishes a National Nurse Service Corps to provide scholarships to nursing students who agree to work in health care facilities that are critically short of nurses.

It also provides for public service announcements and nursing recruitment grants to promote nursing and caregiving careers. The PSAs will serve to educate the public about what a nurse or caregiver actually does, and how this kind of job can be very rewarding. New nursing recruitment grants will help health care providers and schools recruit and educate young people about what we all do. They will also help people trying to get training pay for services like transportation and child-care.

The Nurse Reinvestment Act also establishes a career ladder grant program to help Nurses afford more training and education so they can advance to the next level of nursing. And the bill expands Medicare coverage for clinical nurse training to non-hospital providers and increases a federal Medicaid match for nursing home clinical education of nurses to provide 90% of state costs. And finally, the House legislation provides for grants to develop public-private partnerships between hospitals, nursing schools, and high schools interested in health training programs for young people modeled on work being done in Santa Barbara.

The bill has broad bipartisan support, with 193 cosponsors, and it is my hope that the Congress will move quickly on this issue. So Mr. Chairman, I am pleased that this Committee is holding this hearing and bringing the Congress' attention on this issue.

APPENDIX M – SUBMITTED FOR THE RECORD, STATEMENT OF CONGRESSMAN RUSH HOLT, 12TH DISTRICT OF NEW JERSEY, U.S. HOUSE OF REPRESENTATIVES, SEPTEMBER 25, 2001

Please submit—
Rush Holt

STATEMENT OF REP. RUSH HOLT
COMMITTEE ON EDUCATION AND THE WORKFORCE
HEARING ON THE NURSING SHORTAGE
SEPTEMBER 25, 2001

Today we are facing nursing and nurse educator shortages that pose a major threat to the quality of healthcare all Americans expect and deserve. More importantly these shortages threaten the healthcare of our elderly, one of society's most vulnerable populations.

Today, there are about 35 million Americans aged 65 and older. This number will double to about 70 million in 2030.

Older individuals have more complex health care needs and often multiple conditions that require treatment simultaneously. This means nurses and the care they provide will be even more important than they are today.

The impact of the nursing shortage on our aging population is compounded by the fact that our nursing workforce is also aging.

Fifty percent of all working nurses will reach retirement age in 15 years.

The average age of Registered Nurses is 43.3 years.

And nurses under age 30 comprise less than 10 percent of today's nurse workforce.

Also, minorities, including men, remain a minuscule percentage of the workforce.

The cumulative effect of all this is that New Jersey and many other states across this country are experiencing nursing shortages as more nurses retire, fewer people go into nursing, and the economy offers more opportunities for nurses and higher salaries than nursing.

And it is expected to get worse.

New Jersey will face a shortage of 14,000 registered nurses over the next five years.

Today's shortage is causing great distress not only for our patients but also for our nurses.

According to a new survey by the American Nurses Association, 75 percent of nurses surveyed feel the quality of nursing care at the facility in which they work has declined over the past two years.

About half of the nurses surveyed feel "exhausted and discouraged" when they leave work, and over half of those surveyed would not recommend their profession to their children or their friends. Nurses tell me that they feel undervalued, overworked, and underpaid.

In this country in 1999, a nurse with 15 or more years of experience could expect to earn on average only about $7,000 more than a nurse with three years experience or less.

But nurses are truly the unsung heroes in health care. They are advocates, medical professionals, and healers who fight death and disease and bring compassion to the patients for whom they care. The care they give is high-tech, high-touch, and highly skilled.

Nurses are at the bedside of premature infants in the neonatal intensive care unit, they are assisting in the operating room during cardiac bypass surgery, they are traveling in inclement weather to provide home health care to rural seniors, and they are helping nursing home residents manage complex medications.

Why are people not coming into nursing and why aren't they staying?

One reason is because while nurses have sophisticated training and education, they get skimpy and spartan pay and respect.

We need more nurses, but we as a society must get behind our nurses. That means more than just additional financial aid or bigger scholarships. And it definitely means more than collecting data about the problem.

Getting behind our nurses means paying them what they deserve. Because the dedication and devotion shown by countless nurses doesn't pay the mortgage! And because the best way to recruit more nurses is by having a satisfied nursing workforce that reaches out to a new generation of women and men.

I am proud to support legislation that was recently introduced by Representatives Lois Capps, Carolyn McCarthy, and Eddie Bernice Johnson – all of whom are former nurses.

I am proud to also support efforts to provide Medicaid reimbursement to all nurse practitioners and clinical nurse specialists. This will help increase access to quality care for the country's unserved and underserved populations.

I look forward to hearing from our witnesses today. We need ideas for solutions that work. We must look at what nurses, hospitals, nursing schools, states, Congress and the federal government can do to combat this crisis.

I know that my colleagues on both sides of the aisle care deeply about this issue, and I look forward to working with all of you on finding a solution. Thank you.

APPENDIX N – SUBMITTED FOR THE RECORD, LETTER FROM GEORGE R. BOGGS, PRESIDENT AND CEO, AMERICAN ASSOCIATION OF COMMUNITY COLLEGES, WASHINGTON, D.C., TO BONNIE LEBOLD, EXECUTIVE DIRECTOR, NATIONAL ADVISORY COMMITTEE ON INSTITUTIONAL QUALITY AND INTEGRITY, U.S. DEPARTMENT OF EDUCATION, WASHINGTON, D.C., AUGUST 27, 2001

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August 27, 2001

Bonnie LeBold
Executive Director
National Advisory Committee on
Institutional Quality and Integrity
U.S. Department of Education
1990 K Street, NW
Washington, DC 20006-7592

Dear Ms. LeBold:

I write as President of the American Association of Community Colleges (AACC). AACC represents nearly 1,100 regionally accredited, public and private, associate degree-granting institutions of higher education. AACC submits the following comments regarding the Commission on Collegiate Nursing Education's (CCNE) petition for renewal of recognition by the Secretary of Education as a reliable authority to assess the quality of education offered by institutions engaged in professional nursing education. AACC is joined in these comments by the Association of Community College Trustees (ACCT) and the National Association of State Universities and Land Grant Colleges (NASULGC).

AACC, and the organizations joining us in these comments, believe that there are a number of extremely important issues that relate to the recognition of CCNE as one of the agencies recognized for the accreditation of professional nursing education. We call these issues to the attention of the Advisory Committee so that it can more fully advise the Secretary as it considers CCNE's petition.

The Advisory Committee should understand that CCNE, despite its name—Commission on *Collegiate* Nursing Education—has chosen to limit its scope of accreditation exclusively to programs leading to the bachelor of science in nursing (BSN) and graduate nursing degrees. This choice excludes approximately 860 *collegiate* associate degree nursing (ADN) programs, which currently graduate approximately 60 percent of the nation's new registered nurses (RN) each year. This bifurcation of accreditation for collegiate registered nursing programs has immense social significance for access into the profession, diversity of the nation's registered nurses, and quality of health care. In all but one state (North Dakota), holders of both the ADN and the BSN are licensed to practice as registered nurses with identical scopes of practice.

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Despite this commonality of outcome, or perhaps precisely because of it, a number of the organizations representing BSN programs have systematically and aggressively attempted to separate their programs, and thus their graduates, from those of our institutions. Their goal is to create two categories of licensure, reducing ADN graduates to a status lower than that of BSN graduates. These organizations, of which CCNE is an active participant, have openly indicated their intent to limit the status of "professional" nurse to those possessing the BSN. The CCNE petition before the Advisory Committee is an important component of this campaign.

The effort to devalue the standing of graduates of professional nursing programs who hold an ADN is contrary to the public interest. As the Advisory Committee is no doubt aware, the United States is in the midst of a serious nursing shortage. Our country's population is growing and aging, but graduates of nursing programs are declining, with the shortage approaching a crisis in some regions. According to data from the National Council of State Boards of Nursing, the number of first-time, U.S. educated graduates taking the NCLEX-RN examination declined 26% from 1995-2000. A recent American Hospital Association survey indicated that 126,000 RN positions are unfilled. In addition, 75 percent of the hospitals surveyed reported that it was more difficult to recruit nurses now than it was a year previously. Yet CCNE and its allies seek to reduce the availability of professional nurses by relegating ADN graduates to a lower status—limiting their scope of practice and their economic opportunities. These changes would severely affect the 60 percent of the nation's RNs that receive ADNs. Why? What possible public interest is served b this effort

We are compelled to conclude that advancing the public interest is not the reason our colleagues in the baccalaureate nursing community seek to differentiate BSN from ADN graduates. Instead, this action appears to be part of an effort to protect the BSN programs, many of which are suffering enrollment declines, rather than one to seriously improve the quality of professional nursing education. If ADN graduates are restricted in their scope of practice and thus have fewer career options, BSN programs would be more attractive to potential enrollees, despite the fact that the cost to students in both time and money is significantly greater for BSN than ADN programs.

Were there evidence that the quality of care afforded patients by BSN-credentialed RNs was superior to that provided by RNs with an ADN, the distinction sought by those in the baccalaureate nursing community might be justifiable. But that is not the case. RNs in both groups perform the same work, and every objective analysis demonstrates that they perform that work equally well. No clinical research findings exist to support the premise that BSN graduates provide superior health care services. We can only view the strategy of the baccalaureate community, of which CCNE is an integral part, as one of simple protectionism.

We are also compelled to note that this kind of self-serving behavior seems to represent but another example of a specialized accrediting agency seeking to go beyond a legitimate mandate of examining the quality of programs and the competence of their graduates to trying to impose broad rules that dictate matters of institutional or sector policies, often without regard for the overall mission and responsibilities of colleges or universities.

It is in this context that the Advisory Committee must consider the CCNE petition. AACC particularly urges the committee to consider the implications of CCNE's limited scope of accreditation as it bears on the following issues:

1) CCNE's artificially limited scope of accreditation will restrict access to the profession. At a time of a severe national nursing shortage, nursing opportunit should be enhanced, not restricted. Registered nurses holding associate degrees currently make up approximately 60 percent of all candidates who sit for the National Council Licensure Examination for Registered Nurses (NCLEX-RN). The current pass rate for ADN graduates is virtually identical to that of BSN graduates. By artificially limiting its scope to BSN programs, CCNE is in effect devaluing ADN programs, although both lead to precisely the same professional license. The predictable consequence will be to discourage students from entering ADN programs at a time of urgent national need.

2) CCNE's artificially limited scope of accreditation will contribute to an unwarranted limited scope of practice for associate degree nurse graduates. Organizations representing the baccalaureate nursing community openly seek to limit the scope of practice for persons holding an associate degree in nursing. This approach, euphemistically called "competency-based role differentiation," is designed, we believe, to motivate students to enroll in BSN programs instead of more efficient ADN programs. Given that ADN graduates score as well as (and in most years better than) BSNs on the NCLEX exam used for state licensure, the assertion of "competency-based role differentiation" is nothing but a subterfuge for protectionism. CCNE's limitation of scope creates the perception that ADN graduates are not as qualified at a clinical level to handle professional RN responsibilities as are BSN graduates. In reality, however, there is no material difference in the training afforded ADN and BSN graduates when it comes to competency to deliver quality professional care as a RN. That being the case, there is no basis for CCNE to limit its scope of accreditation, *except* to support the false primacy of BSN programs.

3) CCNE's artificially limited scope will impair the ability of associate degree students to continue their studies. Community colleges historically serve as portals to upper division programs, and this is no less the case in nursing than in other fields. As a matter of long-standing practice, our institutions encourage those graduates who are interested in nursing administration or becoming nurse practitioners or specialists to pursue other advanced nursing credentials. ADN graduates can begin working in hospitals, nursing homes, doctors' offices, etc., while at the same time they may

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attend universities to complete advanced nursing degrees. A ready transfer of academic credits is essential to this process. CCNE's limited scope of accreditation is likely to make it more difficult for ADN graduates to move on to further education at the university level.

4) CCNE's artificially limited scope will have negative implications for diversity in the nursing profession. Higher percentages of African American, Hispanic, and Native American students graduate with ADNs than BSNs. In general, ADN graduates are likely to be older than BSNs and are more likely to come from rural areas, where the need for registered nurses is the highest. Consequently, the effect of CCNE's limited scope in devaluing the ADN is contrary to the Department of Education's commitment to equity and to ensuring a diverse as well as skilled nursing profession. It is also likely to reduce the quality of health care in rural and remote regions of the country that are served predominantly by ADNs.

In summary, AACC is concerned that by limiting its scope of accreditation to baccalaureate and graduate nursing programs, and in doing so consciously ignoring the larger cohort of associate degree professional nursing programs, CCNE has created an artificial and potentially harmful division in professional nursing education. While AACC does not object to the continued recognition of CCNE, we urge the Advisory Committee to require that, as a condition of unqualified recognition, CCNE demonstrate that its limited scope of accreditation is in fact in the public interest and is not directly or indirectly harmful to access to the profession or to the educational and professional opportunities open to ADN graduates.

Please also accept this letter as expressing the interest of AACC to appear before the Advisory Committee in respect to the renewal of CCNE's recognition. Thank you for your consideration of these views. Please do not hesitate to contact me if you have any questions on this topic.

Sincerely,

George R. Boggs

George R. Boggs
President and CEO

cc: Ray Taylor, ACCT
Peter McGrath, NASULGC

APPENDIX O – SUBMITTED FOR THE RECORD, STATEMENT OF KAREN DRENKARD, RN, MSN, CNAA, CHIEF NURSE EXECUTIVE, INOVA HEALTH SYSTEM, FALLS CHURCH, VA, SEPTEMBER 11, 2001

INOVA HEALTH
SYSTEM

Written Testimony
US House of Representatives
Committee on Education and the Workforce
The Nursing Shortage: Causes, Impact and Innovative Remedies
Tuesday, September 11, 2001

Prepared by: Karen Drenkard, RN, MSN, CNAA
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Retention and recruitment of adequate numbers of qualified registered nurses are the major concerns of health care institutions across the nation. There is a critical national shortage of nurses available or willing to fill vacant positions in hospitals, nursing homes, and home care. Registered nurses vacancy and turnover rates range from 6-22% across the country. Reports about hospitals delaying or canceling elective surgeries, closing beds, and emergency department diversions due to short staffing are becoming more frequent. Having an adequate and competent nationwide nursing workforce is imperative to meet the aging population's health care needs. Innovative remedies are possible by creating momentum towards implementing tactics to reach a shared national vision for nursing. There is a shared responsibility among all stakeholders to alleviate the nursing shortage. This testimony will review causes of the nursing shortage, the impact on the care delivery system, and innovative remedies that one healthcare system is implementing with success. Suggestions for the national agenda are also included.

1. Causes of Nursing Shortage

In February 2001, the Bureau of Health Professions Division of Nursing at the Health Resources and Services Administration (HRSA) released the results from the March 2000 *National Sample Survey of Registered Nurses*.[1] The story it tells for nurses is one of shortages over the next decade, with the demand (especially for hospital nurses) outstripping supply by the year 2010. The causes of the nursing shortage include:

- Aging nursing workforce
- Decrease in nursing school enrollment
- Increased opportunities for women in expanded career roles, accompanied by a poor image of nursing as a career

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[1] Health Resources Administration Services (HRSA), March 2000, National Sample Survey of Registered Nurses

- Low unemployment rates
- Job intensity
- Increase in acuity and need for health care services in an aging baby boomer population

Aging Nurses

The large numbers of RNs that entered the workforce in the 1970s are now over the age of 40 and are not being replaced by younger RNs. According to the HHS March 2000 *National Sample Survey of Registered Nurses*, [1] the average age of an RN is approximately 45. The national average is expected to increase and as nurses retire, the total number of nurses in the United States will decline steadily.

Decrease in Nursing Program Enrollment

Recruiting into the profession is increasingly difficult. Enrollments for entry-level bachelor's degree nursing programs decreased 17 percent from 1996-2000, according to the American Association of Colleges of Nursing, Washington, D.C. Yet, certain areas in the country are experiencing a swell in applications, with state colleges and universities unable to handle the volume, citing an aging nursing instructor pool. Recruitment of nursing instructors is increasingly difficult, and some areas and regions are unable to admit nursing students into the nursing programs.

Increased Opportunities for Women in Expanded Career Roles, Accompanied by a Poor Image of Nursing as a Career

As early as 1989 [2], a study of students' perceptions of the nursing profession revealed that young people believed nursing was a low-status, low-paid career with little room for advancement. Media portrayal of nursing did little to change that impression. During the last two to three decades, opportunities for women in traditionally male roles were opened up, and many young people chose other options. These factors combined to cause a decrease in nursing enrollments across the nation.

Low Unemployment Rates

The national unemployment rate for RNs is at its lowest level in more than a decade, continuing to decline from 1.5 percent in 1997 to 1.0 percent in 2000. At the state level, changes in nurse employment from 1996 to 2000 varied widely, from a 16.2 percent increase in Louisiana to a 19.5 percent decrease in Alaska. [3] This low unemployment rate translates into a high demand for registered nurses, with an ever-shrinking pool of nurses to draw from.

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[2] Grossman, Divina, MSN,RN, et. Al., *High School Perceptions of Nursing as a Career: A Pilot Study*, Journal of Nursing Education, Volume28 (1): 18-21.

Job Intensity

Job dissatisfaction has also been identified as a significant factor in retaining and recruiting nurses. A recent Federation of Nurses and Health Professional (FNHP) [3] survey found that half of the currently employed RNs who were surveyed had considered leaving nursing for reasons other than retirement over the past 2 years. This same finding was confirmed in a national poll conducted by the Healthcare Advisory Board in 2001. [4]

Increase in Acuity and Need for Health Care Services

About 78 million Americans of the baby boom generation will soon turn 65, retire, and use more health care resources, according to a report in the *Journal of the American Medical Association* (June 14, 2000). By 2020, when the boomer retirement is in full swing, the nation will be short more than 400,000 nurses, or 20 percent of those needed.

Increased acuity and volume, heavy workloads, and the increased use of overtime are listed as key areas of job dissatisfaction among nurses. According to the FNHP survey, [3] nurses want a less stressful and less physically demanding job.

Hospital work is by far the hardest work an RN can perform. And it has become harder because of shorter lengths of stay combined with high-acuity patients, added paperwork generated by managed care, and increased oversight for medical errors and malpractice.

2. The Impact on Health Care Delivery Systems

The dwindling supply of registered nurses across the county is beginning to be felt, with the impact including:

- Increased use of agency, travelers, and other contingency staffing
- Increased costs due to turnover and recruitment [4]
- Closing of emergency department and critical care beds due to inadequate supply of nurses
- Increasing vacancy and turnover rates across the country. Average RN vacancy and turnover rates range from 6 – 22 percent with a national average rate of 17 percent. An industry survey indicated turnover rates for overall hospital nursing department staff rising from 11.7 percent in 1998 to 26.2 percent in 2000. [5] Coupled with the shortage of nurses employed is the concern about retaining nurses.

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2 Federation of Nurses and Health Professionals, *The Nurse Shortage: Perspectives from Current Direct Care Nurses and Former Direct Care Nurses* (opinion research study conducted by Peter D. Hart Research Associates, Washington, D.C. 2001)

3 Healthcare Advisory Board, *Survey of Nurses Job Satisfaction*, December 2000, Nursing Executive Center, Washington D.C.

[4] Joinson, C., *Capturing Turnover Costs*, HR Magazine July 2000: 107-119

[5] Hospital and Healthcare Compensation Service, Hospital Salary and Benefits Report, 2000-2001, (Oakland, N.J.: Hospital and Healthcare Compensation Service, 2000)

- Increasing use of overtime to staff patient care areas, with concerns about mandatory overtime for nurses
- High cost of utilizing external staff and overtime as a strategy to staff units
- Increased complaints from patients and physicians
- Increased nurse dissatisfaction, with some estimates as high as 30% of nurses thinking of leaving their jobs within the next two years [6]
- Patient safety issues
- Loss of patient trust in the health care delivery system
- Increase in days to fill RN positions in organizations, with a national average of 28 days for a medical surgical nurse to 39 days for a critical care nurse [6]

With the average age of current RNs at 42 – 44, the impending retirement of approximately one-third of the nursing workforce in the next 10 years could be catastrophic. For a system of Inova's size, that is a projected loss of 1,200 nurses to retirement by the year 2012.

3. Innovative Remedies

Inova Health System, an integrated, not-for-profit, health care system in Northern Virginia, has been on a journey of strategic planning for nursing and reaching an Employer of Choice model to meet targets of lowered vacancy rates, reduced turnover rates, and the creation of a hardy, committed, challenged nursing workforce. The nursing strategic plan provides a roadmap for the future of nursing. A vision was created based on the need for outstanding patient care, and what it will take to make a future worth experiencing for nurses at Inova. Six priority areas were identified that were considered the drivers of change. These include: nursing leadership, organizational culture, organizational learning, nursing practice, nursing research, and role clarity. Each priority area has goals and tactics that provide a dynamic course to achieve the vision. Highlights of the tactics that have been successful as measured by outcomes include:

- Serving as an alpha site with the Healthcare Advisory Board H*Works company to implement the role of Chief Retention Officer for nurse managers, and a program for new hire support for new graduate nurses, to ease the transition from school to work
- Continual market competitiveness for salary and benefits with ongoing review of salary indicators
- Development and implementation of the Inova Institute for Nursing Excellence that recognizes outstanding clinical expertise in nurses, provides career advancement support, acknowledges and rewards clinical excellence, celebrates nurses, and will further a research agenda in nursing
- Implementation of a Nursing Exploration Summer Camp 2001, in partnership with the Fairfax County Public Schools and the George Mason University School of Nursing and Health Sciences. Twenty-two (22) students were enrolled in the first year, with the goal to improve the image of nursing in youth. More information is available at the Nursing Executive Center Healthcare Advisory Board's website. (www.advisory.com)

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[6] The Nursing Executive Center, *The Nurse Perspective: Drivers of Nurse Satisfaction and Turnover*, The Advisory Board Company, Washington, D.C., 2000.

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- Development and implementation of a revamped, staff developed four-step professional clinical ladder for nurses practicing at the bedside. This clinical ladder is accompanied by a 6 percent step increase in pay for each level of the ladder reached. The ladder includes shared leadership and peer determination of promotion.
- State-of-the-art fellowships and internships to "grow our own" nurses in the hard-to- recruit clinical areas
- Use of large group intervention conferences [7] to engage nurses across the system in generating ideas to improve retention, and explore the "next generation" to work as nurses
- Role clarity of key nursing jobs, including the Licensed Practical Nurse (LPN) and Registered Nurse (RN) roles
- Strengthening the advanced practice clinical nurse specialty role
- Increasing clinical educator support on the units
- Creation of a nursing executive "dashboard" that allows for monthly review of best practices across similar units regarding quality, cost, satisfaction, and turnover and vacancy rates
- Clinical focus on the basics of nursing care: Medication and patient safety, pain management, restraints, moderate sedation, documentation, and patient education. This emphasis on nursing excellence matches the core indicators for magnet status awarded by the American Nurses Credentialing Center (ANCC)
- Evidence-based research and clinical policy development to raise the level of nursing practice
- A newly defined orientation process for new graduates combining clinical and social support
- Implementation of a nurse mentorship program that has paired 196 nursing students with 150 Inova nurses since the fall of 2000
- Achievement of Magnet Status (ANCC – American Nurses Credentialing Center) of our flagship hospital, with an ongoing assessment of all other Inova hospitals to assess readiness for application

Outcomes are monitored routinely, and preliminary results for 2001 reflect average vacancy rates of RNs across the system are declining from a high in December 2000 of 16 percent to 11 percent in April 2001. Likewise, turnover rates at Inova Health System have declined from an average of 1.4 percent per month in December 2000 to 1 percent in April 2001. This summer, 128 new graduate nurses are starting at Inova Health System, a 20% increase from last year. The use of external agency nurses holds at only 4 percent of total hours worked.

Inova Fairfax Hospital's designation as an ANCC Magnet Hospital means that our level of education of nurses is high; that the support systems are in place for nurses to advance their practice; education and research agendas have support for implementation; and in general holds out a commitment of resources to nurses to provide the best care possible. The combination of attention to the "hard stuff" of salary, benefits and scheduling must be accompanied by the "soft stuff" of culture, leadership, and training and development at all staff levels.

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[7] Bunker, BB, Alban, BT, Large Group Interventions: Engaging the Whole System for Rapid Change, Jossey-Bass: San Francisco, 1997.

4. Creating a National Agenda

A national effort is essential to turn the nursing shortage around. There is a shared responsibility among all stakeholders to alleviate the nursing shortage. Suggestions for innovative remedies include:

- **Commit to a methodology for creating a national vision for the future**, and plan strategically to meet the vision.
    - Create a nationwide vision for nursing
    - Assure that the work is data-driven and data-analyzed, evaluating supply and demand factors
    - Improve processes that are needed for nurses to provide excellent patient care, such as reducing paperwork requirements
    - Strive for a coordinated, comprehensive, and common ground approach including all stakeholders in the process (nurses, physicians, patients, payors, administrators, etc)

- **Focus on increasing the number of nurses that enter into practice** and advancing careers internally.
    - Scholarship money - tap into pools of the new generation of children whose parents have emmigrated to this country and provide them scholarship money for healthcare careers
    - Provide funding that encourages increasing the pool of nurses from the minority and male population
    - Increase funding to colleges and universities to increase class size by increasing and improving nursing lab space and classrooms
    - Develop a plan to increase nursing faculty
    - Assess areas that have colleges and universities with waiting lists for nursing students, and prioritize funding to those educational institutions to increase class size.

- **Improve the image of nursing**: Provide funding for a media image campaign (nursing as a positive profession) similar to the language in the Nurses Reinvestment Act (S. 706 and H.R. 1436), and scholarship and retraining monies for a nursing corps loan repayment program, scholarship program, and public awareness and education campaign found in the Nurse Employment and Education Development (NEED) Act (S.721).

    - Provide grant monies for innovative youth programs such as Inova's Nursing Exploration Summer Camp 2001 to encourage youth to consider nursing as a career.
    - National, regional and local media campaigns to stress nursing as a positive career choice for men and women
    - Foster professional leadership models where shared leadership can flourish

- **Transform the role of the RN** - Create a national forum for discussion on recrafting the role of the RN to meet the increased technological demands with the inevitable decrease in supply of nurses, along with RN roles that support the aging RN population.
    - Examine care delivery systems

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  - Focus on retention, flexible scheduling, supporting new hires (the"soft stuff")
  - Use patient outcomes as measures (not staffing ratios and legislated guidelines for care)

- **Collect meaningful data** across the country so that trends can be identified and examined, and appropriate action can be taken based on information
  - Creation of Workforce Data Centers on a national and state wide level

- It is incumbent on health care delivery systems to **address workplace issues** and decrease job intensity. This includes creating environments consistent with the Magnet Hospitals (ANCC) that have shared leadership, flexible scheduling, competitive salaries and benefits, high percentage of BSN and MSN nurses, adequate staffing, excellent continuing education programs, and support for new graduate nurses.

- **Modify reimbursement methodologies** that allow nursing care to be reimbursed directly so that revenues can go directly to improving nursing staffing capabilities.

Additional References

Aiken, Linda H, Havens, D.S., Sloane, D.M., *The Magnet Nursing Services Recognition Program: A Comparison of Two Groups of Magnet Hospitals*, American Journal of Nursing, Volume 100 (3), p. 26-36.

Buerhaus, P., et al. *Implications of an Aging Registered Nurse Workforce*, Journal of the American Medical Association, June 14, 2000: 2948.

Drenkard, KN, *Creating a Future Worth Experiencing: Nursing Strategic Planning in an Integrated Healthcare Delivery System*, Journal of Nursing Administration, Vol 31(7/8): 364-376.

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APPENDIX P – SUBMITTED FOR THE RECORD, STATEMENT OF DEBORAH A. CHAMBERS, CRNA MHSA, PRESIDENT, AMERICAN ASSOCIATION OF NURSE ANESTHETISTS – FEDERAL GOVERNMENT AFFAIRS OFFICE, WASHINGTON, D.C., SEPTEMBER 24, 2001

AANA

September 24, 2001

Hon. John Boehner, M.C.
Chairman
House Education and Workforce Committee
2175 Rayburn Bldg.
Washington, DC 20515

Hon. George Miller, M.C.
Ranking Member
House Education and Workforce Committee
2175 Rayburn Bldg.
Washington, DC 20515

Dear Mr. Chairman and Ranking Member:

Thank you for hosting a hearing Sept. 25, 2001, to examine the impacts of and possible solutions to the burgeoning shortage of nurses. On behalf of the 28,000 members of the American Association of Nurse Anesthetists, I would like to provide you our perspective – that there is also a shortage of Certified Registered Nurse Anesthetists (CRNAs), and to briefly outline proposed solutions.

The shortage of nurses and of CRNAs hurts Americans' access to quality health care. It can be remedied in part by helping to train additional nurses and CRNAs. With the Federal government playing such a large role in funding and assuring health care access through Medicare and other programs, the Federal government has an interest and some responsibility to help reverse the shortage of nurses and nurse anesthetists.

Who are nurse anesthetists? America's 28,000 CRNAs are the sole anesthesia providers in two-thirds of all rural hospitals, and the predominant anesthesia providers in urban underserved communities and for the men and women in the U.S. Armed Forces. We provide 65 percent of the 26 million anesthetics delivered safely to patients in every State, in every setting in which anesthetics are required, each year. We are referred to as "advanced practice" nurses who have secured specialized additional training and certification in anesthesia. And we meet the most stringent continuing education and recertification requirements in the field. Thanks in part to advances in technology, education and practice, the Institute of Medicine reports anesthesia is 50 times safer than 20 years ago.

The Nurse Anesthetist Shortage

The forces driving the nurse anesthesia shortage are similar to those causing the general nursing shortage, with a few additional factors. The number of Medicare-eligible retirees is projected to increase, from some 34 million today, to over 40 million just ten years from now. And an aging CRNA workforce, a rapidly growing demand for surgical and invasive diagnostic procedures, and filled to capacity nurse anesthesia educational programs are all factors aggravating the shortage.

- A survey of all directors of accredited nurse anesthesia programs, conducted by the American Association of Nurse Anesthetists (AANA) Education Department in February 2001, revealed that the average number of qualified applicants that each program was unable to accept in 2000 was 23.

- In a 2001 administrative managers' survey conducted by the AANA, 62% of the managers surveyed reported an average job vacancy rate of 3.5 FTE CRNAs, an increase of 14% since the 1998 survey. They reported an increased CRNA demand as the result of a greater number of surgical cases requiring anesthesia services. Seventy-four percent of these managers stated that it currently takes them an average of 6 months to a year to fill their vacancies.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS - FEDERAL GOVERNMENT AFFAIRS OFFICE
The Capitol Hill Office Building, 412 1st Street, S.E., Suite 12, Washington, D.C. 20003
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- An article from the March 2001 issue of the *OR Manager* (Vol. 17, no.3) reveals that hospitals are not able to offer as many surgeries or pain management services due to the shortage of anesthesia providers. Additionally, the article discloses that the nation is already short of 1,000 anesthetists (both CRNAs and anesthesiologists alike), with a projected shortfall of 7,000 by the year 2005. The article further provided the results of a survey of 90 hospitals in Massachusetts which revealed that about 28 hospitals closed because of forced closure of operating rooms or the elimination of pain management services due to the shortage.

- The Division of Nursing's 2000 Sample Survey of Registered Nurses shows that more than 40% of nurses are aged 50 and over. A 2001 AANA Membership survey reveals that this is true for CRNAs as well, where 40% of the members surveyed are over the age of 50. The survey also indicates that the average age of CRNAs working in rural hospitals with less than 500 surgeries annually is over 50 years old, comprising 50% of this rural hospital workforce. It is predicted that about 38% of the 28,000 CRNAs active in the workforce will be eligible for retirement in the next 5 years, thus exacerbating the current shortage of nurse anesthetists.

Proposed Solutions

We have the wherewithal to help alleviate these challenges, within a fiscally responsible and balanced Federal budget.

- We should provide targeted increased funding for nursing education through appropriations to currently authorized programs. The Federal government, through appropriated education programs and mandatory funding (such as the Graduate Medical Education and Nursing & Allied Health Education programs financed through the Medicare Part A Trust Fund), spends more than ten times as much training each anesthesiologist as it does each nurse anesthetist. This occurs notwithstanding comparable patient outcomes according to every published study, and the significant cost savings advantage of employing CRNAs. It is therefore highly cost-effective for the Federal government to help fund the training of CRNAs as anesthesia providers. For FY 2002, we have recommended an increase in appropriations of $11 million for the Advanced Education Nursing program, part of Title VIII of the Public Health Service Act, to at least $70 million. A portion of this appropriation helps to increase the amount of competitively awarded funding available to expand CRNA schools and traineeships for student nurse anesthetists.

- We have supported new authorizing legislation (HR 1436, Capps-Kelly) establishing a Nurse Service Corps, providing scholarships and loan repayments to every type of nurse, including nurse anesthetists, who agree to service in rural and other underserved areas. This same legislation also authorizes funding to help train additional faculty to teach nurses and nurse anesthetists.

- We have joined with Americans for Nursing Shortage Relief (ANSR), a coalition predominantly made up of nursing organizations, to seek and identify a consensus agenda for alleviating the nursing shortage. In addition to the above measures, ANSR promotes education of and outreach to potential nursing students as means to reduce the nursing shortage over the long term.

- We are also examining other factors that discourage the training of CRNAs, and proposing ways to resolve them. For example, certain aspects of Medicare reimbursement and regulation

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discourage the training of nurse anesthetists. We are working in other venues to improve these so-called teaching rules.

- Lastly, but perhaps most importantly, we are taking responsibility ourselves to identify and mentor young people into the nursing profession, and specifically into the field of nurse anesthesia. Through our committee structure and through individual members, we understand and recognize that behind each excellent caregiver is a mentor in the field.

The House Committee on Education and the Workforce possesses legislative jurisdiction in several areas important to helping resolve the nursing shortage and the shortage of nurse anesthetists. It has authority over Labor Department workforce activities, over elementary and secondary education programs that impact young people's perception of nursing as a career option, and over student financial aid and other aspects of higher education that helps finance nursing education.

We look forward to working with the Committee as it grapples with helping to reverse a shortage of nurses and of nurse anesthetists. If you have any further questions, please feel free to contact me, or Dave Hebert and Frank Purcell of our Washington DC office.

Sincerely,

Deborah A. Chambers

Deborah A. Chambers, CRNA MHSA
President

CC: Members of the House Committee on Education and the Workforce

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APPENDIX Q – SUBMITTED FOR THE RECORD, STATEMENT OF DR. PAUL KINSER, PROVOST OF THE WEST CAMPUS, VALENCIA COMMUNITY COLLEGE AND NANCY DINON, VICE PRESIDENT, HUMAN RESOURCES, ORLANDO REGIONAL HEALTHCARE, ON BEHALF OF PARTNERS FOR A HEALTHY COMMUNITY, SEPTEMBER 25, 2001

Testimony of
Dr. Paul Kinser
Provost of the West Campus
Valencia Community College

and

Ms. Nancy Dinon
Vice President, Human Resources
Orlando Regional Healthcare

on behalf of

Partners for a Healthy Community
Institutions of higher education and health care providers serving
Lake, Orange, Osceola, Seminole, and Sumter counties in Central Florida, including

Florida Hospital
Health Central
Lake-Sumter Community College
Orlando Regional Healthcare
Osceola Regional Medical Center
Seminole Community College
University of Central Florida
Valencia Community College

September 25, 2001

We are pleased to have the opportunity to share with Congress the work that the Partners for a Healthy Community are undertaking in Central Florida related to the nursing shortage, and to provide information about specific needs for which federal funds could be of assistance to us. The Partners for a Healthy Community include four health care providers and four institutions of higher education serving a five-county area in Central Florida, including Florida Hospital, Health Central, Lake-Sumter Community College, Orlando Regional Healthcare, Osceola Regional Medical Center, Seminole Community College, the University of Central Florida, and Valencia Community College.

The growing national nursing shortage has the public and the health care community concerned about quality of patient care. In the year 2000, the U.S. Department of Health and Human Services projected a national shortfall of 258,000 nurses. In Florida alone, the number of licensed registered nurses fell from 225,173 in 1998, to168,198 in 1999. As a result, there are approximately 5,100 currently unfilled registered nurse positions in Florida and the number is expected to grow significantly in coming years.

In 2000, the total R.N. vacancy rate in Central Florida's rural areas was 12 percent while in urban areas it was 11.3 percent, and the R.N. turnover rate was 21 percent for rural areas and 18 percent for urban areas.

The reasons for these unfilled vacancies are generally attributed to the aging nurse population, a national decrease in nursing school enrollments, and an increase in health care demands for our aging population. In Central Florida however, demand for nursing school slots continues to outpace supply, giving us an immediate opportunity to increase enrollment. Two-thirds of working nurses are over the age of 40, and, in general, nurses work less as they age. Applications to all degree levels of nursing programs are decreasing: from 1994 to 1995, the number of applications received by associate degree, diploma, and baccalaureate degree nursing programs decreased by 16.3%, 36.1%, and 8.8%, respectively. The demand has been so great that the United States has even encouraged the aggressive recruitment and employment of R.N.'s from other countries.

The institutions of higher education in the Partnership currently offer degree programs in Nursing, R,N. The programs provide students with a broad scientific background as well as first-hand experience in "people care". The programs are approved by the State Board of Nursing and are accredited by the National League for Nursing Accrediting Commission (NLNAC).

The student demand and success-level being experienced by the Associate in Science Degree , R.N. Nursing program at Valencia Community College are representative of the situations of the higher education partners involved in the Partnership. The demand for health-related training is evidenced by enrollment in Valencia's program, where enrollment totals approximately 300 students annually and graduate placement rates have averaged over 98 percent over the past three years. Over 3,500 students have graduated from Valencia's R.N. program since the first class graduated in 1970, and graduates consistently score above the national and state first time pass rates on their licensure examinations.

Over 30 percent of Valencia nursing students identify themselves as belonging to ethnic minority groups, which is 200 percent higher than the race/ethnicity of the national R.N. population (approximately 53 percent of Hispanic nurses enter their nursing careers through associate degree programs, compared to just over 37 percent of all RNs). According to Healthy People 2010, in 1995-96, 14.2 percent of nursing program graduates were minorities. The goal of Healthy People 2010 is 30 percent by 2010. Valencia already meets this goal and, given the projected minority population growth for the two counties served, will far exceed it by 2010.

Valencia Community College's highly-successful Nursing, R.N., A.S. degree program is a selective admission, limited enrollment two-year program, and the competition for available spots is extremely high because current facility and fiscal restraints limit the number of students that the college can train in a given year. The college has received commitments for the current and next fiscal years of $720,000 from private sector hospital partners to increase faculty by 12 and to increase class size from 168 to 220 in 2001-02.

The Partners for a Healthy Community urge the Congress to consider offering federal support for nursing faculty positions, for additional financial aid for nursing students, and for curriculum development and piloting of "Fast Track" programs that can serve as national models to produce nursing graduates in a shorter period of time. For example, Valencia currently offers an accelerated track model program for licensed practical nurses (LPNs) who are studying to become registered nurses. With federal support, other "Fast Track" programs could be added.

On behalf of the Partners for a Healthy Community, we thank the Members of Congress for their recognition of the price that is paid in both human and economic terms when quality health care is compromised in our communities. We appreciate very much your efforts to direct federal funding to address this crisis that is being felt in communities all across the nation.

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APPENDIX R – SUBMITTED FOR THE RECORD, STATEMENT OF PREMIER, INC., WASHINGTON, D.C., SEPTEMBER 25, 2001, AND LETTERS FROM HERB KUHN, CORPORATE VICE PRESIDENT, ADVOCACY TO THE HONORABLE TOMMY TOMPSON, SECRETARY OF HEALTH AND HUMAN SERVICES, SEPTEMBER 20, 2001 AND THE HONORABLE ROD PAIGE, SECRETARY OF EDUCATION, JANUARY 22, 2001

PREMIER

STATEMENT FOR THE RECORD

PREMIER, INC.
A NOT-FOR-PROFIT HOSPITAL ALLIANCE

"THE NURSING SHORTAGE: CAUSES, IMPACT AND INNOVATIVE REMEDIES"

COMMITTEE ON EDUCATION AND THE WORKFORCE
UNITED STATES HOUSE OF REPRESENTATIVES

SEPTEMBER 25, 2001

On behalf of Premier, Inc., a strategic alliance of more than 1,800 leading not-for-profit hospitals and health systems, we express our deepest sympathy to all those who lost loved ones or were otherwise affected by the tragic events of Sept. 11. Our thoughts and prayers are with the victims and their families. We are extremely grateful for the tireless, selfless efforts of the police, fire, rescue, and healthcare workers who placed the safety and wellbeing of others far above their own.

INTRODUCTION

That healthcare providers across the nation are experiencing an unprecedented shortage in nurse staffing—a shortage nearing critical mass—has been documented extensively by the panel of witnesses testifying before this Committee. Through the disquieting narrative and anecdotal documentation we have received from our own hospitals, Premier seeks to imbue the statistics with tangibility; to show that *real* institutions suffer *actual* harm as a result of nurse staffing shortages. Premier will also illustrate how *individual* hospitals and health providers, while aggressively advocating for state and national remedies, have mobilized their internal resources to combat nurse staffing shortages in their own backyards.

In addition, in light of imminent military engagement by our nation, we would ask the Committee to examine and discuss remedial options for potential health staff shortages subsequent to the activation of personnel who are members of the National Guard or Reserves.

BACKGROUND

As workforce shortages near historic levels in industries across America, those involving critical sectors of the healthcare delivery system are particularly severe. As reports issued in the last six months by the General Accounting Office (GAO) and Congressional Research Service (CRS) underscore, significant nurse staffing shortages (as well as those

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involving other health professionals) are emerging regionally—undoubtedly representative of what is soon to become a national trend. The dynamic will undoubtedly worsen as "baby boomers" transition into retirement and add to an already burgeoning population of elderly requiring health care services.

DISCUSSION

Health workforce shortages have multiple roots, with those involving salary or wages among the most significant. The current dearth of registered nurses (RNs), perhaps the most critical of all healthcare workforce shortages, has been thus characterized. The Harvard Nursing Research Institute reports that RN earnings dropped nearly two percent a year from 1993 to 1997, as hospitals were forced to ration diminished resources in the face of financial pressure from Medicare cuts and managed care cost controls. Hospital nursing shortages gained national prominence in 1998, and now plague nearly every region in the country, with shortfalls in the western U.S. particularly acute. While intensive care units and operating rooms appear to be suffering the most, RN shortages have spread—not unlike dominoes—to numerous other hospital departments.

A July 2001 GAO report, *Nursing Workforce: Emerging Nurse Shortages Due to Multiple Factors*, described the current and future challenges hospitals face:

- *The number of employed RNs per capita has declined in recent years while the national unemployment rate for RNs declined to 1 percent in 2000.*
- *Providers from around the country are reporting growing difficulty recruiting nurses to work in a range of settings, and surveys of providers in several states and localities indicate rising RN vacancy rates.*
- *The future demand for nurses is expected to increase dramatically as the baby boomers reach their 60s, 70s, and beyond. Moreover, the nurse workforce will continue to age, and by 2010, approximately 40 percent will likely be older than 50.*

In preparing its report, the GAO asked Premier to survey its hospitals for RN vacancy rates. Based on the information gathered from 54 respondents representing 204 Premier hospitals and health systems, our internal survey (subject to a one-week turn-around) yielded an average vacancy rate of 11 percent. This figure correlated with a recent, much broader study conducted by the American Hospital Association (AHA). (Our findings are illustrated by region in the attached document.)

THE NURSING SHORTAGE: PERSPECTIVES FROM PREMIER HOSPITALS

- The nursing shortage experienced by Kettering Medical Center in Ohio has forced the suspension of six intensive care units and ten acute care beds, despite unabated patient demand. The shortage has also generated overcrowding in the emergency department, forcing the transfer of patients to facilities outside their community.

- The experience of Bon Secours Health System in New Jersey is typical of healthcare providers across the state, where the critical care, nursery, and surgery units are the hardest hit by RN shortages. Bon Secours has implemented new incentive programs to reduce these staffing shortfalls.

- New Hanover Regional Medical Center administrators have met with the North Carolina congressional delegation to propose a K-12 "careers in healthcare" pilot program, in conjunction with the state department of education. New Hanover Regional, itself, has instituted a RN retention and recruitment committee, a career orientation program for teens, and an RN mentoring initiative. It hopes to extend its successful radiology technician "distance learning" project to nurses-in-training. In this program, technicians are paid full-time wages while they master the textual/reading components of their instruction/certification off-location, i.e., via the Internet. New Hanover reports that participants are extremely appreciative of the opportunity to study off-site and of the investment the organization has made in them.

- To maintain appropriate levels of nurse and technician staffing in the short term, Wayne Memorial Hospital, NC, has had to engage in costly international recruitment, an extra/weekend shift incentive plan, salary enhancements, sign-on bonuses, and an employee referral program. Over the long term, Wayne Memorial is exploring partnerships with community colleges to establish scholarships with service payback and stipend, and an RN internship program at the secondary school level.

- The Cleveland Clinic Foundation, OH, has experienced sizeable difficulty recruiting and retaining experienced nurses, pharmacists and radiology technicians, all while volume and patient acuity are on the rise. Academic institutions have inundated the Clinic with requests for funding to hire more faculty and increase the physical capacity of their nursing programs. Clinic administrators have campaigned to increase student access to tuition subsidies.

- Legacy Health of Oregon and PeaceHealth Systems of Washington have sought to create partnerships with local and community colleges to streamline the healthcare career pathway and establish scholarship programs for RN candidates.

- Like many rural providers, Geisinger Health System Foundation, PA, has had an especially difficult time recruiting and retaining nurses. Geisinger has been vocal at the state level where the legislature is debating a bill to boost funding for RN student loans. Administrators testified in favor of the legislation earlier this year.

- The University of Texas—M.D. Anderson Cancer Center has been at the forefront of efforts across the state to identify, address, and remedy nurse-staffing shortages. An Anderson administrator currently chair the Texas Medical Center Nursing Shortage Task Force, and serves on the National Advisory Council on Nurse Education and Practice, and the Greater Houston Partnership Subcommittee on the Nursing Work Environment. M.D. Anderson was recently recognized by Premier for demonstrating exemplary employer/workplace regard for nurses.

- Methodist Hospital, located in Dallas, Texas, faces an extreme nursing shortage in acute care. It has been forced to staff the ER with pool or agency nurses, leaving other departments comparably vulnerable.

RECOMMENDATIONS

Earlier this year, Premier wrote a letter on behalf of its hospitals and health systems to Education Secretary Rodney Paige to draw attention to the growing educational needs of our nation's healthcare system. Premier strongly urges the Bush administration to address and remedy the deficiencies therein as it develops and fine-tunes its education agenda.

Recognizing the existence of numerous options like employer payroll tax relief and Public Health Service program reform, Premier maintains that President Bush's education bill could be instrumental in reversing the national healthcare staffing shortage in two fundamental areas. (Premier's Jan. 22 letter to Secretary Paige is attached.)

- First, Premier believes federal funds ought to be made available for faculty development. Reports from hospitals across the country indicate that many young people wish to enter the healthcare profession, but are *unable* as a result of limited space in the requisite classes. Boosting faculties, in order to expand course offerings, would be of enormous help. To that end, Premier has endorsed the "Nurse Reinvestment Act (HR. 1436/S. 706), and the "Nursing Employment and Education Development Fund," or NEED (S. 721). These bills would
    - establish a national nursing service corps;
    - expand Medicare and Medicaid funding for clinical nursing education, and for reimbursement of home health agencies and nursing homes for RN training;
    - provide grants to develop and fund recruitment and retention strategies, with an emphasis on acute shortage areas; and
    - establish scholarship and loan programs to encourage RN graduate education.

- Second, Premier believes that increased education funding to train healthcare staff in new patient safety and information technologies is critical. Hospitals are moving aggressively to address the issues raised by the Institute of Medicine's November 1999 report, *To Err Is Human*, and its March 2001 sequel, *Crossing the Quality Chasm: A New Health System for the 21st Century*. However, inadequate capitol to finance the technology and train staff to manage these new systems (i.e. physician order-entry, bedside verification, and pharmacy dispensing systems) represents a sizeable barrier. Premier strongly recommends that the Bush education bill provide program assistance to allow hospitals and other providers to develop the education and training programs to meet this critical need.

- A third initiative Premier considers worthy of resource allocation, development, expansion, and investment is "distance learning" for registered nurses, either actively employed or looking to re-enter the workforce, to update skills, certification and credentials, or enhance training for clinical specialization.

PENDING MILITARY ACTION

In a letter sent last week to HHS Secretary Tommy Thompson, Premier praises the department's efforts to strengthen and streamline the delivery of health services during this most recent national crisis. We also express our concern over how the military activation of key health personnel may affect currently under-served communities. It is not surprising that many healthcare practitioners who are critical to the delivery of health care in their communities *also* serve in the U.S. military. Premier has asked the Secretary to consider convening a meeting among providers to discuss the likely impact of activation and how subsequent shortages of key community caregivers may be alleviated. America faced such a dilemma nearly a decade ago when health leaders who also served in the Reserves or National Guard were called to duty, leaving their communities with a shortage of critical healthcare personnel. Premier is eager to work with the Department, on behalf of its hospitals and health systems, to develop remedial options. (Premier's Sept. 20 letter to the Secretary is attached.)

* * *

Premier, Inc. is a strategic alliance of more than 1,800 leading not-for-profit hospitals and health systems nationwide. The Premier family of companies provides an array of resources in support of health services delivery, including e-commerce enabled group purchasing. Premier maintains a keen focus on improved patient safety and quality improvement initiatives, including healthcare informatics, clinical technology/best-practice products and services, insurance consulting, and physician practice management.

Through its efforts to influence the outcome of health policy initiatives on both the legislative and regulatory fronts, Premier Advocacy, based in Washington, DC, strives to create an environment most conducive to the delivery of safe, high-quality, cost-effective care. As reflected by its products and services, Premier Advocacy is owner-driven, grassroots-oriented and value-based. Premier, Inc. operates other facilities in San Diego, CA; Charlotte, NC; and Chicago, IL.

PREMIER

September 20, 2001

The Honorable Tommy Thompson
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Thompson:

On behalf of Premier, Inc., a strategic alliance of more than 1,800 leading not-for-profit hospitals and health systems, we express our gratitude for your leadership in the wake of the tragic events of September 11. Your tireless efforts to strengthen and streamline the healthcare delivery process for those affected by these developments have been critical and deeply appreciated.

Activation of healthcare personnel who are members of the Reserves or National Guard may become necessary as our nation readies itself to respond to this crisis. It is no surprise that many of them who serve critical roles in their communities also serve in the U.S. military

As the likelihood of activation increases, we would ask your assistance in convening a meeting as soon as practicable among affected groups, including hospitals, community health centers, rural health clinics, and nursing homes, to discuss the process and how we may best communicate that information with the leadership of our facilities. In addition, we stand ready to partner with you to ensure that *should* key healthcare personnel be called into duty, plans are established to address the need for temporary replacements in the most affected areas. During the Persian Gulf War, many communities experienced difficulty when such personnel were called to serve their country.

As you know, attracting healthcare practitioners to serve in certain shortage areas—impoverished urban areas and remote rural communities, in particular—is not easy. Should personnel from those and other areas be called to serve, finding temporary replacements may prove extremely difficult. Therefore, we would be pleased to work with you as remedial options are developed. One such option, for instance, would be the temporary assignment of individuals from the uniformed corps of the Public Health Service to serve in those areas where healthcare practitioners are called to duty.

Again, thank you for your leadership in this time of crisis. Please contact me or Matthew Williams, federal affairs director, with questions or comments.

Sincerely,

Herb Kuhn
Corporate Vice President
Advocacy

PREMIER

January 22, 2001

The Honorable Rod Paige
Secretary
U.S. Department of Education
400 Maryland Avenue, SW
Washington, DC 20202

Dear Secretary Paige:

On behalf of Premier, Inc., an alliance of more than 1,800 not-for-profit hospitals, we wish to draw your attention to the growing educational needs of our nation's healthcare system. We strongly urge you to address and remedy the deficiencies therein as you develop and fine-tune the President's agenda for education.

In industries across America, workforce shortages are near historic levels. Those involving sectors of the healthcare delivery system—nursing, pharmacy, and other hospital departments, in particular—are especially acute. Those intimately involved in the day-to-day management of healthcare predict that the workforce situation—already troublesome in certain communities—will worsen as baby boomers transition into retirement and add to an already burgeoning population of elderly requiring healthcare services.

A telling indicator of the growing problem of workforce shortages is the resurgence of emergency department "divert" status. Several national, state, and local news reports have examined patient access to timely emergency care, as more hospitals are forced to temporarily close their emergency departments. While the issues surrounding "divert" status are complex, administrators' inability to adequately staff the hospital is a large contributing factor. Veterans in healthcare believe the "divert" status is equivalent to the "canary in the coal mine" indicator—an early, yet critical warning that assistance is needed.

More specifically, the shortage of nurses and pharmacists has taken a serious toll on the delivery of health care. The hospital nursing shortage has spread nationwide and is deepening. It is particularly acute in inner cities and rural areas. The emerging shortfall of licensed pharmacists was most recently documented in a report issued in December 2000 by the Health Resources and Services Administration (HRSA). The report traces the problem to an increased demand for pharmacists and a "constrained ability to increase the supply." The report concludes that the contributing factors are "not likely to abate in the near future," and points to education as a key vehicle for addressing the problem.

Given the historic proportions of our healthcare system's growing workforce shortages, we urge you to examine innovative remedies in the context of the President's evolving education program. While many options exist—employer payroll tax relief, changes in key Public Health Service programs, etc.—we believe the President's education bill could be instrumental in two fundamental areas.

First, we believe federal funds should be made available for faculty development. Reports from hospitals across the country indicate that many young people wish to enter the healthcare profession, but are unable to as a result of limited space in the requisite classes. Boosting faculties, in order to expand course offerings, would be of enormous help.

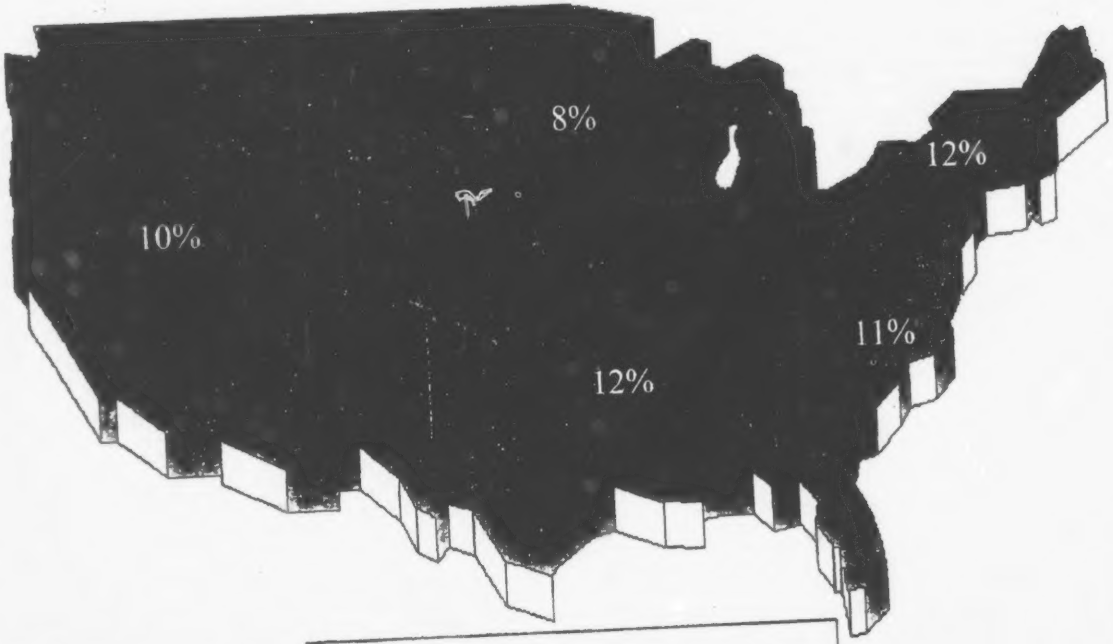
Second, increased education funding to train healthcare staff in patient safety technology is critical. Hospitals are moving aggressively to address the issues raised by the Institute of Medicine's November 1999 report, *To Err Is Human*. However, inadequate capitol to finance the technology and train staff to manage these new systems (i.e. physician order-entry, bedside verification, and pharmacy dispensing systems) is a sizeable barrier. We strongly recommend that the President's education bill provide program assistance to allow hospitals and other providers to develop the education and training programs to meet this critical need.

The President's education agenda presents an opportunity to address not only our nation's public education needs, but its healthcare education needs, as well. We look forward to working with you on this important national priority.

Sincerely,

Herb Kuhn
Corporate Vice President
Advocacy

Average Registered Nurse Vacancy Rates*



Regions
New England: ME, NH, VT, RI, CT, MA, NY, PA, NJ
South Atlantic: DE, MD, DC, WV, VA, NC, SC, GA, FL
South Central: KY, TN, AL, MS, OK, AR, LA, TX
Midwest: WI, MI, OH, IN, IL, MO, KS, NE, SD, ND, MN, IA
West: CA, OR, WA, ID, MT, WY, NV, UT, CO, AZ, NM
(Does not include HI and AK)

**Based on information provided by Premier owners in June 2001. 64 respondents representing 204 hospitals.*

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APPENDIX S – SUBMITTED FOR THE RECORD, STATEMENT OF THE AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES, SEPTEMBER 25, 2001

STATEMENT FOR THE RECORD
OF THE
AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES
(AFSCME)
FOR THE U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON EDUCATION AND THE WORKFORCE
HEARING ON
"THE NURSING SHORTAGE: CAUSES, IMPACT AND INNOVATIVE REMEDIES"

SEPTEMBER 25, 2001

The American Federation of State, County and Municipal Employees (AFSCME) appreciates the opportunity to submit this statement for the record to the Committee on Education and the Workforce on the important issue of the nursing shortage. AFSCME represents over 50,000 nurses who work in a variety of health care settings across the country. The impact of the nursing shortage is being felt firsthand by nurses as they try to provide quality care to their patients. They express to us frustration, stress and even sadness about how serious the problem of inadequate staffing has become.

Background

Nurses play a central role in delivering patient care. As indicated by research on nurse staffing and patient outcomes, sufficient numbers of nurses are needed if patients are to receive quality care.[1] While insufficient staffing is not a problem in all health care facilities today, it is widespread.

Shortages have occurred in health care throughout history, especially since World War II. Nursing shortages have historically been cyclical and economy based. When the economy has been thriving and unemployment percentages have been low, a nursing shortage has been likely to follow. However, much of the current shortage is rooted in the transition to managed care and a focus on the financial bottom line that led many workplaces to restructure the delivery of care and cut nursing staff during the 1990s.

A study published in the January/February 1999 issue of *Health Affairs*[2] evaluated the impact of managed care on demand for nurses. It found that in states with high HMO enrollment through 1996, there was a noticeable slowdown in RN employment growth and a shift to out-of-hospital employment.

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[1] "Nurse Staffing Levels and Adverse Events Following Surgery in U.S. Hospitals," Christine Kovner and Peter J. Gergen, *Image: Journal of Nursing Scholarship*, Fourth Quarter 1998.

[2] "Trouble in the Nurse Labor Market? Recent Trends and Future Outlook," Peter I. Buerhaus and Douglas Staiger, *Health Affairs*, January/February 1999.

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The shift to managed care has resulted in increased average acuity of hospital inpatients; increased demand for highly skilled and experienced specialty nurses; growing demands on nurses to perform housekeeping and other tasks previously performed by other staff; and insufficient staffing and even layoffs of nurses.

Today's Nursing Shortage

Discontent Among Nurses

While the aging of the nursing workforce and reduction in nursing school enrollments has implications for the future, the current shortage is affected by workplace issues that are forcing many nurses to leave the field. Concerns about impossible patient loads, insufficient support staff, the abuse of mandatory overtime, unsafe working conditions and the lack of opportunity to be involved in decision-making are causing many nurses to leave the workplace.

AFSCME nurses report that they are increasingly concerned that quality of care is being jeopardized by insufficient nursing staff. Not only are there not enough nurses to do what needs to be done on any given shift, but the nurses who are on duty are fatigued, stressed and harried.

Studies in health care have reached the same conclusion: The state of nursing is in critical condition and something needs to be done about it. For example:

- Researchers at the University of Pennsylvania have found widespread concern about quality of patient care and discontent in the ranks of hospital nurses and have identified alarming trends that bode ill for a quick resolution to the current nurse shortage.[3]

The study documented widespread nurse dissatisfaction and growing concern for patient well-being in the survey of registered nurses. The investigators concluded that fundamental problems with management of care in hospitals and working conditions for nurses may contribute to medical errors and other undesirable consequences for patients. Nurses reported that they are unable to provide quality of care consistent with professional standards in today's hospitals.

Mandatory Overtime

One particular effect of the nursing shortage that demands an immediate solution is the growing practice of requiring nurses to work beyond their scheduled hours to meet regular staffing needs. Rather than retain adequate nursing staff, many employers routinely coerce or require nurses to work overtime hours. This method of staffing and scheduling is not only onerous for nurses, but has significant consequences for patient care. Relying on exhausted nurses to deliver care creates an environment where medical errors and poor quality care are inevitable.

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[3] "Nurses' Reports of Hospital Quality of Care and Working Conditions in Five Countries," L.A. Aiken, S.P. Clarke, D.M. Sloane, J.A. Sochalski, et al., *Health Affairs*, May/June 2001.

As patient advocates, nurses are increasingly concerned that mandatory overtime is detrimental to the quality of care provided. Consequently, mandatory overtime was a major factor in bitter, protracted strikes by nurses in several states in the last few years, notably in New York, California, Massachusetts, Pennsylvania, Michigan and in the District of Columbia.

In order to protect the public, Congress and previous administrations have acted to curtail the use of overtime in the transportation industry. The need to address mandatory overtime in health care is just as compelling. Nurses must be able to refuse overtime work when they believe they do not have the capacity to properly care for patients.

The Future Supply of Nurses

Encouraging Enrollment in Schools of Nursing

Schools of nursing report decreases in the number of students entering nursing programs. Clearly, there is a need to develop policies to increase enrollment. But these efforts will be undermined if there is not a simultaneous effort to address the problems that are encouraging nurses to leave the profession. The effort to attract more students to nursing through loan programs or tax mechanisms will be defeated by the growing and more persuasive recognition that nursing is not a desirable profession.

Increasing Immigration

Resorting to the increased use of immigrant nurses will not solve the nursing crisis. In fact, it may exacerbate it by encouraging policymakers and health care employers to avoid making fundamental changes that will improve the quality of care, retain nurses and make nursing an attractive career option. Because the U.S. has the capacity to address the nursing crisis, it is inappropriate to drain health care personnel from other nations with more limited resources and capacity. In many areas of the world, the only health care available is that provided by a limited supply of nurses. Raiding these countries for nurses jeopardizes the health and well-being of their citizens.

Conclusion

While it is important to look for solutions to increasing the number of students who enter nursing, it will not solve staffing problems that threaten patient health and safety today. The workplace environment must be improved to retain current nursing staff and attract prospective nurses.

APPENDIX T – SUBMITTED FOR THE RECORD, STATEMENT OF THE EMPLOYMENT POLICY FOUNDATION, WASHINGTON, D.C., SEPTEMBER 25, 2001

Statement by

Employment Policy Foundation

Submitted to

U.S. House of Representatives
Committee on Education and the Workforce

Hearing on
The Nursing Shortage: Causes, Impact and Innovative Remedies

September 25, 2001

Critical Labor Shortages Challenge Traditional Education and Workforce Policies

Introduction

The Employment Policy Foundation (EPF) is pleased to provide the committee the benefit of its research and analysis regarding the critical labor shortages facing the nation today and into the future. EPF is a non-profit, non-partisan research and educational foundation located in Washington, D.C. EPF research focuses on employment trends and the impact of public policy on the capacity, productivity and prosperity of the American workplace.

The nursing shortage that is the subject of this hearing is a manifestation of a pervasive labor and skills shortage facing the American workplace. Shortages of skilled workers have been emerging over the past decade in a broad spectrum of occupations – in health care, in information technology, in professional services and in skilled construction and production crafts. The signs of labor shortage in critical growth occupations continue despite immediate concerns about slower growth, recession and rising unemployment. In the nursing profession, for example, the unemployment rate has remained unchanged over the past year and remains – at 1.2 percent – among the lowest of any occupation.

Short-term economic fluctuations are important, and immediate needs for monetary and fiscal stimulus policies correctly focus our attention, but the long-term reality remains the expectation of strong growth potential and persistent labor shortage. Policy action to deal with the long-term threat should be on-going and should not be postponed by short-term conditions.

The nursing shortage that concerns the committee today should be viewed in the context of the overall long-term shortage of skilled labor. Policy proposals that address the problem in a piecemeal fashion are likely to be ineffective. The labor and skill shortage is a broad problem and solutions require a broad re-thinking of national policies, programs and incentives that affect individual choices regarding training for and participation in the labor force.

Shortages Across Many Occupations are Linked

Shortages in one field are shifted to related fields as workers adapt their education and skills to opportunities most in demand. The shortage of skilled workers and the competition to attract and retain them is evident in rising wages, increased non-wage compensation, better working conditions and innovative work arrangements. The era of lifelong employment in a single occupation is past. Rising turnover shows the willingness of employees – in response to changing opportunities – to change employers and to change careers. Employers who are unable – because of technical, institutional or regulatory constraints – to respond to the diverse needs of employees in this competitive labor market environment risk being unable to fulfill the demands of their customers because the employees they need to do the job have moved to more attractive opportunities.

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The competition among industries and occupations for skilled and motivated employees is evident in the conditions affecting the supply of nurses. Nurses are highly educated and experienced in both human relations and technology. Their training enables them to observe, analyze and assimilate information quickly. These traits that make nurses so valuable in the emergency room, the operating theatre, and the hospital ward also make them ideal candidates for responsible and rewarding jobs in other fields. Nurses increasingly are finding new jobs and new careers in managerial, information technology, training and sales opportunities in health-related settings other than hospitals and in non-health fields. Of experienced hospital-based nurses aged 35-44 in 1990, nearly 25 percent – more than 125,000 – had left hospital jobs by 2000 to pursue careers in other nursing settings or in other fields altogether. Higher education attainment increases career mobility: More than one third – 60,000 – hospital-based nurses who had post-baccalaureate degrees in 1990 left hospital service over the following decade, and most appear to have left the nursing occupation altogether.

The shortage of skills is not distinct from the general shortage of labor. To the extent that current education and training patterns persist, the aggregate labor shortage will be manifested primarily as a shortage of higher skilled workers. Increasing investment in education and training to shift the available workforce toward filling skill needs may, to some extent, result in shortages of lower skill occupations. The fundamental problem is that the expected total workforce will be inadequate to fulfill the demands for goods and services of an increasingly older, non-working population. Solutions lie in policies to promote greater productivity of available labor, to increase the rate of participation of the available population in the workforce and to increase the population available to work through immigration.

The Outlook: Widespread Future Shortages Across the Occupation Spectrum

Shortages in a wide range of occupations that are evident today provide a glimpse of greater shortages to come. Current trends point to chronic shortages across the entire spectrum of the occupations and industries, but most especially in those that offer the greatest potential source for economic growth and rising incomes over the next 30 years. Over the next 30 years, the labor force needed to maintain current per capita growth in the standard of living will increase to nearly 200 million, but current growth of the working age population, productivity growth trends and current labor force participation rates point to an available labor force of only 165 million. The shortage may reach a total of 35 million workers – 21 percent more than the available labor force – in 2031. (See Figure 1.)

The shortage will be widespread, but most acute in the industries and occupations that are leading the growth of the American economy – information technology, management related occupations, professional services, high-skill production and construction crafts, health care and technical support services. All of these occupations have one thing in common – requirement for specialized and intensive post-secondary education. Many of the occupations most in demand today and in the future require college level analytical, critical thinking, communication and quantitative skills. The ability to work in an environment of technical sophistication, innovation and rapidly changing knowledge requirements will be essential.

Unless current patterns of education and training change, the United States may be 12 million to 15 million short of the number of four-year college degree graduates needed by 2031. Needed graduates of post secondary vocational and two-year academic degree programs may also fall far short – as much as 15 million to 18 million, depending on the extent to which employers demand completion of systematic training and certification of knowledge and skills.

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Increasingly, jobs that once required no more than a high school education and brief on-the-job training are now requiring specialized training and technical sophistication at the post-secondary level. Completion of a systematic, progressive program of study and training ensures the ability to be highly productive on the job from the start and demonstrates the ability to learn efficiently and to adapt to new challenges and skill requirements in the future – both requirements for success in the highly competitive and fast changing global economy. The increasing mobility of the workforce, job turnover and dynamics of company staffing plans suggest that objective certification of training, skills and knowledge will become more important in the years ahead.

Currently the number of persons who have completed post-secondary vocational or two-year academic programs are outnumbered two-to-one by persons with assorted post-secondary coursework, but no degree to demonstrate clear skills and accomplishments. (See Figure 2.) Solving the skills shortage may require significant effort to increase the rate of vocational and two-year degree program completion as well as the rate of four-year degree completion.

Causes of the Labor and Skills Shortage

The labor and skills shortage is the outcome of forces that have been shaping the American economy for the much of the past century and that promise to accelerate in strength in the coming years. Rapid technological change, increasing global economic integration and increased longevity are inter-related and mutually reinforcing forces of economic change. Their impact over the last 50 years is evident in every aspect of our lives today, and their influence for the future is inexorable.

Technological change has made employees more productive – a result that on the surface would argue against a shortage of labor. Technology enables each of us to produce more than was possible before. However, to be able to use more productive tools and processes, employees often need more knowledge and technical sophistication. They need more analytical and quantitative skills than in the past. The impact of technology on the education and skill requirements of jobs across the spectrum of occupations is particularly evident in the change in typical educational attainment for employees in technical, craft and administrative support occupations since 1970. In 1970, a high school diploma and on-the-job training was sufficient for most jobs in this broad mid-skill category – only 20 percent had any post-secondary education. Today, 50 percent of these employees have some post-secondary education. Among younger workers the proportion is even higher, and the trend indicates a 75 percent post-secondary educational attainment level by 2031. (See Figure 3.)

The impact of global economic integration is evident in today's labor market and will become more significant in the future as a driving force of the demand for a more skilled and educated American workforce. The fastest growing occupations over the past 30 years have been in managerial occupations, professional services and information technology. Much of this growth has been tied to the growing role of American companies in the leadership of global production and service enterprises. As the concentration of lower skilled assembly and operations jobs has shifted overseas, the role of Americans in management, professional and technical services to maintain the global productive enterprise has grown.

From the purely national perspective, the traditional pyramid of occupations – a few management related jobs atop a broad base of assembly and manual labor jobs – appears to be turning upside-down as management and professional jobs in America grow faster than any other category. (See Figure 4.) The management and professional occupational group now outnumbers the other three major occupation groups and comprises 30 percent of all jobs – a proportion that may rise to more than 40 percent by 2031. This shift is made possible by the global integration of markets and by the ability of American workers increasingly to occupy the management, information technology and professional services tier of a global production pyramid.

Increasing longevity and the aging of American society extenuates the labor shortage. The retirement of large cohorts of the "baby-boom" boom generation will leave large gaps in the supply of labor – gaps that the smaller population cohorts now under 35 will be inadequate to fill based on current labor force participation patterns. At the same time, these retirees will live longer, continuing to contribute to the total consumption demand that national output must satisfy. The growing retired population will also have at its disposal significant purchasing power – retirement savings, pensions and Social Security benefits – with which to make its consumption demand effective.

We would already be in the midst of a more severe labor shortage today had it not been for increased labor force participation by women over the past 30 years. Female and male participation rates are quickly converging. Thirty years ago, the female labor force participation rate was half that of males. Today, it is more than 80 percent of the male participation rate, and the difference is closing rapidly. The difference may disappear within the next 12 years to 18 years if the current trend persists. Our ability to rely on further increases in participation of women to bridge the labor force gap will be limited.

Approaches for Bridging the Labor and Skills Gap

The labor and skills shortage changes the fundamental paradigm of employment policy for the American workplace. Policy action to cope with this challenge is needed now, before conditions become critical. Past policies reflected assumptions of scarce jobs, constant structure of production and occupation relationships and sameness in organizations and job arrangements. Future polices will need to reflect the new realities of scarce labor, increasing skill and education requirements, and dynamic competitive needs and opportunities. Policies to increase incentives to seek and access to obtain training and education must be emphasized to address the skills deficit aspect of the problem, but that will not enough. The fundamental shortage of labor regardless of skill distribution must also be addressed. Three policy strategies are relevant:

- **Policies to increase participation.** At 67 percent, the U.S. labor force participation rate is the highest among the G-8 countries, but some room for increase remains. Continuing to close the gap between male and female participation will help, but not suffice. The longer-living retired population is another important source. Flexibility is an important factor influencing participation. Flexibility encompasses schedules, work locations and employment arrangements. Parents balancing work and family responsibilities can be encouraged to participate in the labor force by schedule options that enable them to compress work time within a month or to choose compensatory time off in exchange for overtime. Flexible work place options – such as telecommuting – are feasible means of increasing participation in many of the fastest growing occupation categories. Flexible work arrangements – self employed contracting, for example – can be very effective means to increase participation for individuals with special needs or abilities.

  Flexibility also is important for older potential workers. Phased retirement—involving flexibility of both schedule and employment arrangement – is a concept that appeals to many workers who are nearing retirement, but effective implementation of the concept has been limited. Compensation is also a consideration in participation decisions of many potential workers – especially older ones. For many, the tax treatment of Social Security benefits results in a significant disincentive to workforce participation.

Congress should thoroughly examine all aspects of current employment and tax policies to identify obstacles to flexibility and other incentives for labor force participation.

- **Policies to increase productivity.** Increased productivity, brought about by new tools, new technology and better training, enables the available workforce to produce more. Over the past 20 years annual productivity growth has averaged 1.8 percent. EPF's labor shortage projection – 35 million cumulative over 30 years – incorporates this productivity growth rate. Higher productivity growth would reduce the labor shortage. We have occasionally achieved higher productivity growth for short periods – the average rate between 1995 and 2000 was 2.6 percent. Significant progress to bridge the labor shortage gap will require sustained productivity growth above 2.1 percent for decades. Policies to achieve sustained increases in productivity must address the risks and rewards of investment in research, physical capital and training.
- **Immigration.** Approaches to increase labor force participation of the existing population and to raise productivity offer great promise toward bridging the labor supply gap, but they may not be enough. Immigration policy should be reviewed to ensure that American workplaces have access to talented and motivated workers from abroad to fill critical labor shortages. Current immigration policy gives a low priority to employment based immigration, and often places administrative barriers in the way of effective recruiting of foreign talent by American employers. New approaches need to be developed that will promote coordination of immigration patterns and labor force needs.

Consequences of the Failure to Solve the Labor and Skills Shortage

Failure to deal effectively with the looming labor and skills shortage will have serious consequences for the American people:

1. **Lower than expected standard of living.** Real per capita income, now at $30,236, may grow to only $48,010 by 2031 instead of the $58,660 level that reflects the historical trend of the past 30 years.

2. **Increased trade and balance of payments deficits.** Retired baby-boomers may spend their substantial savings to buy larger proportions of imported goods and services if domestic production is inadequate. The result could be to transform their sizeable retirement savings into foreign ownership of American assets and companies, instead of recycling their retirement consumption into continuing prosperity for future generations of Americans.

3. **Growing structural unemployment.** Failure to shift training and education patterns toward meeting growing high skills demand may leave a surplus of inadequately skilled workers to compete for jobs in the lower skill occupations where demand growth is expected to be slower.

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4. **Price distortions.** Competition for increasingly scarce labor will lead to increases in compensation costs, which may be passed on by employers in higher prices, causing either relative price changes that disrupt expected resource allocation patterns or a cost-push inflation cycle.

5. **Loss of strategic industrial base.** Increased difficulty filling needs for skilled craft and technical talent domestically may accelerate existing patterns of relocation of production and service center abroad. This tendency would be exacerbated by cost-push price distortions as firms react to tough global competition.

6. **Growing income inequality.** Failure to address the skills imbalance aspect of the labor shortage could magnify current income differences between occupations with different education and skill requirements. The result could be growing social alienation and demands to shift resources into new welfare and income maintenance programs.

The reality of America's labor and skill shortage is evident. It transcends short-term concerns arising from business cycles. The shortage is present today, and it will become progressively greater in the future. Even at half the projected labor deficit levels, the problem would be serious – affecting the economic well-being of every American family. Piecemeal policy action directed toward shortages in selected occupations will not address the fundamental issue. Broad policy action to promote greater investment in education and training is needed to address the skills imbalance aspect of the problem. Coordinated efforts to promote greater participation, higher productivity growth and immigration policies that complement labor demand are needed to address effectively the fundamental supply issues. Failure to deal with this challenge will jeopardize the future strength and prosperity of the nation.

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Table of Indexes

Chairman Boehner, 1, 3, 4, 7, 9, 11, 13, 14, 16, 18, 19, 20, 22, 23, 25, 27, 28, 31, 33, 36, 39, 42, 45, 57, 58
Dr. Garner, 45, 49
Mr. Andrews, 31, 32, 33
Mr. Ballenger, 57, 58
Mr. Greenwood, 24, 25
Mr. Isakson, 53, 54
Mr. Kucinich, 51
Mr. Lynn, 49, 50, 54, 56, 57
Mr. McKeon, 33, 45, 47, 49, 50, 51, 53, 54
Mr. Miller, 14, 15, 16, 17
Mr. Norwood, 36
Mr. Osborne, 18, 19
Mr. Scott, 25, 26, 50, 51, 53, 58
Mr. Tierney, 19, 20, 54, 55, 56
Mrs. Biggert, 20, 21, 22
Mrs. Kelly, 16, 17, 18, 20, 21, 22, 23, 26, 30
Mrs. McCarthy, 17, 21, 23, 24, 26, 32
Mrs. Mink, 27
Ms. Bartels, 42, 53, 55, 57, 58
Ms. Foley, 34, 51, 54, 55, 57
Ms. McCullough, 51, 54, 55
Ms. Solis, 28, 29, 30
Ms. Tompkins, 13, 14, 15, 19, 20, 25, 29
Ms. Woolsey, 22, 23

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